STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004667	A. BUILDING: _____ B. WING _____	C 01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTATES OF HYDE PARK, THE	4505 SOUTH DREXEL CHICAGO, IL 60653

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S 000	Initial Comments Complaint investigation: 2180323/IL00130225	S 000		
S9999	Final Observations Statement of licensure findings: 300.1210b) 300.1210 d)3) 300.1210 d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to supervise and monitor a severely psychologically impaired resident(R1). This failure affects one of three residents (R1), reviewed for accidents and supervision in a total sample of three residents.This failure allowed R1 to obtain sharp objects and use those objects to cut herself in the abdomen. R1 was able to seriously injury herself twice, on two different occasions, while she was in the facility. Findings include: R1 is a 36-year-old female former resident of the facility. Her diagnoses include but are not limited to schizophrenia, bipolar disorder, major depressive disorder with psychotic features, anxiety disorder due to psychological condition, suicidal ideations, and intentional self-harm by unspecified sharp object. R1 was admitted to the facility on 10/01/2020. R1 discharged to the hospital on 12/13/2020. A brief review of R1's mental status, (BIMS), notes that R1 is cognitively intact, has depression, and behaviors. These behaviors include: verbal behaviors, such as threatening, screaming, cursing at others, and physical behaviors such as hitting or scratching herself. R1 also is a wanderer. Care area assessment dated 10/05/2020, notes that R1 had a relapse of an underlying mental illness, psychiatric disorder and neurological disease. The care area also notes that she has had thoughts that she would be better off dead or hurting herself in some way. She is restless and verbalized self-harm. She exhibits inappropriate, unsafe behavior related to diagnoses of schizophrenia and bipolar disorder. Suicidal Risk Observation dated 10/13/2020, notes she has a history and current episode of	S9999		

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harming herself. She cut herself with a sharp object. She has attempted suicide. Her most recent attempt was swallowing batteries and cutting herself several times. She has had thoughts about suicide all the time. Her plan to commit suicide was by cutting herself and she is very likely to act on these thoughts. She is high risk, very likely to act on her thoughts, and there is nothing preventing her from committing suicide.

Review of R1's progress notes details the following:
On 10/02/2020, R1 attempted to exit the facility stating that she can't stay here because she's going to harm herself like she did previously or by ingesting something. She stated, "I need to be locked down."
On 10/10/2020, R1 went down to the basement and got out of the basement door. She was redirected and after several attempts she sat in the dining area in the basement. She later proceeded upstairs in the elevator. She returned to her room and was compliant with her medications. Staff will continue to have frequent rounding and monitor resident's safety.
On 10/13/2020, staff informed that R1 was outside of the facility. V4 (Social Services Director) met with R1 to enquire about her concerns. R1 stated, "I just want to kill myself. I don't want to be here. If I spent the night in the facility, you will not see me alive." V4 asked her if she had a plan. She refused to respond stating, "I do and it is none of your business." She refused to answer further questions. She was restless and agitated without provocation. V4 counseled her and she was not receptive to counsel. She tried to escape through the back door four time within two hours. She continued to state that she did not want to be in the facility and that she wanted to go to the hospital. V4 informed R1 that

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the facility cannot hold her against her will. R1 was petitioned to a local hospital for psychological evaluation. R1 was given involuntary discharge and that she has a right to call for hearing with the information on the form.
On 10/14/2020, R1 made several attempts throughout the day to harm herself and others stating, "I am going to f*** you all." R1 was petitioned out to a local hospital after calling her primary care physician. She was aggressive, restless, with mood behavior. She returned from the hospital the same day.
On 10/15/2020, R1 complained of moments of restless/anxiety.
On 10/16/2020, R1 was sent out 911 due to self-inflicted wound to her lower abdomen. She cut herself with a soda can that she cut in half. She refused to let the nurse access the area or take vital signs. V8 (Nurse) and the nursing assistant stayed with her until help arrived. R1 became combative with V8; kicking and swearing at the staff. The ambulance and police departments strapped her to the stretcher for follow up at the nearest hospital. R1 was in her room working on a puzzle when the nurse administered her night medications around 11:00PM. No signs of distress or anxiety was noted. The nursing assistant informed V8 of the incident. R1 was petitioned out of the facility to the nearest hospital.
On 10/17/2020, V8 followed up with the hospital. R1 was admitted medically for laceration to her abdomen.
On 12/12/2020, R1 is a readmission on the day shift. Her vitals are stable. But she declined a full body assessment.
On 12/13/2020, R1 pulled the call light and told V7 (Nursing Assistant) that she needed to be sent to the hospital. V6 (Nurse) went to her room to evaluate her situation because V6 and the

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S9999	Continued From page 4 assistant had rounded and R1 was lying quietly in bed. She did not have any prior concerns. V6 found R1 bleeding from her abdomen with a piece of glass in her hands. V6 compressed the site with towels to control the bleeding. V6 provided care until 911 arrive. R1 told the ambulance that "I could not help myself." R1 refused V6 to take vitals on her. All responsible parties contacted. R1 was admitted for stab wound and psych evaluation. Facility report dated 12/13/2020, documents the incident. V6 asked R1 why she caused trauma to herself. R1 stated that "I don't want to be here because you don't know how to care for me. Also, I stated that she needs a psychiatric facility. Interviews conducted 1/24/2021 to 1/25/2021, document the following: On 1/24/2021, at 11:28AM, V1 (Administrator) stated, R1 is not allowed back in the facility because we cannot care for her. I am afraid that one day she will be dead. This setting was not appropriate. I believe that she told me that she came from psychological facility. R1 was a referral. We saw that she had some issues. I thought to give her another chance. But she has a mental illness that takes over everything else. I was giving her another chance after she had left the facility and then returned. R1 is a danger to herself and others. She is not safe by herself. My understanding is that R1 found some a sharp piece of plastic and she took the plastic and cut herself in the stomach. When staff came back to the room, R1 removed her sheets and showed that she was bleeding from the abdomen. She was on fifteen minutes checks and was ambulatory. She was not allowed to have sharp objects. I expect my staff to follow orders come up with orders. We do not do one-to-one monitoring, but fifteen-minute checks. A one to	S9999		

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one was attempted when she first hurt herself. She did not like that because she cursed us out and asked why staff was watching her. When R1 returned to the facility, she was only in the facility for 36 hours before I got a call. Staff called and told me that she had cut herself again and left the facility. My staff should have checked her room to make sure there was nothing broken, and I should have attempted to put her on one-to-one supervision.

On 1/24/2021, at 12:08PM, V3 (Nursing Assistant) stated, she likes one on one time. She required a lot of supervision because she attempted suicide before she came to the facility. She was not supposed to have sharp instruments. Staff is supposed to have more eyes on her because of her behaviors. She would turn into a baby when there was something in our policies that she could not do. If staff saw her with something, then they would check her room. We would not go into her room, with her permission, and search preemptively. R1 knows how to do stuff to get her way.

On 1/24/2021, at 12:30PM, V4 stated, when was here she has manipulative behaviors. She has exit seeking, self-harm, suicidal behaviors. We educate and console them on their behaviors. Most of the time, the incidents were at night, when she knew there was no one around. The first time she went to another room and got a can from the garbage. Before she came to the facility, my plan was to ensure that she was safe and free from harm. I was told that she did not want anyone around her. R1 is special because during the day she is fine. Several occasions the state guardian stated that R1 did not want to be in the facility.

On 1/24/2021, at 8:51PM, V6 stated, when I came in for work, I noticed that R1 returned. I was passing my evening medications. She was

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coloring. She pulled the light and the aide went to her. She pulled the light again and she told the aide that she needed to go to the hospital. When I went there, I saw some blood on her sheet. I called my colleagues and I noticed that she cut herself in her abdomen. I put some sheets on her and told her to apply pressure. She had a previous incident in our facility, we were watching her closely. No, she is not allowed to have sharp objects. I cannot answer how she got the sharp object. Yes, she is a danger to herself and others. I was not in serviced on R1. We rarely have residents like R1. When I was in the room, I saw her coloring. R1 did not want people too close to her. If not she would flip out. I just used my eyes to scan the room. I did not ask for her permission to check her person or her bed. As a nurse, I would have suggested a one on one to watch her throughout the night. She cut herself with glass in her room.

On 1/24/2021, at 9:02PM, V7 (Nursing Assistant) stated, I was at the front desk talking to the nurse. She pulled the call light. I went in her room and R1 told me that she wanted to go to the hospital. I informed the nurse and the nurse went into the room and noticed that she had harmed herself. When I got to work, the other nursing assistant told me that she could not have anything sharp, batteries, or anything that could harm her in the room. Every fifteen minutes I had to check the resident. I was looking what she was doing. Majority of the time she was sleeping. I never asked her for permission to see what she had. I am not trained to work with psych residents. I just made sure she was alright. When she first got there, I was informed to check her room to make sure she was ok. I would say she is a danger to herself and others. I asked her if she needed anything, she blew up. I just kept my distance. She is a one on one. I am the only

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S9999	Continued From page 7 certified assistant on the first floor at night. Administration knows this. When I went in there, she had a picture on her wall. R1 broke the picture on the wall and used that glass to cut herself. The facility knew that she was not supposed to have sharp objects. There could have been more staff down there with me, since I was the only certified assistant down there by myself to limit harm or risk to the resident. On 1/25/2021, at 1:46PM, V8 (Nurse) stated, R1 is a true psych patient. I was involved with the first incident of her cutting herself. She is a danger to herself and others. I was afraid of her. The CNA grabbed the can from R1 because she was getting ready to cut herself or us. I believe that she got the can from the garbage and cut herself. She was not allowed to have sharp objects. Administration needs to evaluate these residents. We have no knowledge of these residents until they come to the facility. She likes one on one attention. We are not equipped for that. I tried to keep her close to the nurse's station. I am not going to put myself in harm's way. I do not know what her state of mind is. Looking back, I could have been more aware of what she was bringing in the facility. We try to keep clutter free and check on them frequently. I do not think she should have been in our facility. She knew the codes to the doors and if she wanted to leave, she could. In my opinion, she should have never been in this facility. R1's care plan documents the following: R1 has a history of causing self-harm to herself with pencils and other sharp objects; presents with restless behaviors; with mental disorders with moderate to extreme social isolation (when upset), disorganized behavior, agitation, compulsive behavior, excitability, hostility, repetitive movements, and self-harm; at risk for elopement attempts evidenced by trying to leave	S9999		

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S9999	Continued From page 8 the building to smoke without notifying staff; has a diagnosis of schizophrenia; displays behavioral symptoms related to her severe mental illness; has a history of suicidal attempt, ideation, is high risk related to her swallowing batteries and stabbing herself in the stomach with an ink pin; displays moderate impairment with daily decision making; requires cues and supervision related to poor judgement and recent act of self-harm; she cannot have sharp objects (pens, pencils, etc.) due to her attempting to harm herself. R1's care plan interventions include the following: R1 will make safe decisions with verbal cueing and assistance from staff as evidenced by no injuries or clinical decline through next review; provide daily monitoring for safety and support; when exhibiting poor judgement offer advice and guidance; observe for injuries or clinical decline; staff will encourage R1 to attend and participate in one to one intervention; staff will encourage her to report all suicidal ideation; staff will provided one to one counseling when needed; when she is experiencing suicidal ideation staff will talk to R1 about reasons why they would not attempt suicide; staff will continue to encourage resident to voice concerns to staff at all times; provided one to ones when needed; staff will anticipate resident's needs; staff will encourage resident to voice concerns all of the time; resident will have reduced behavioral episodes; allow resident to express feelings and desires. "A"	S9999		