Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005003	A. BUILDING: ______ B. WING ______	C 06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 5-3-21/IL133644 Complaint Investigation 2183170/IL133713	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to monitor and supervise a resident who has a history of two elopement attempts. This failure affected one resident (R1) and has the potential to affect 6 other residents (R2, R3, R4, R5, R6 and R7) on elopement precautions. R1 jumped down through the window opening of the sixth-floor dining room and landed on the ground outside the building, without any staff witnessing the incident. R1 was later pronounced dead at the hospital.

Findings include:

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S9999	Continued From page 2 R1's Face Sheet shows that R1 was originally admitted to the facility on 2/24/21. R1's admitting diagnoses include but are not limited to: Schizophrenia, Schizoaffective Disorder (Depressive type), Suicidal Ideations, Dementia, Major Depressive Disorder, Psychosis, Generalized Anxiety Disorder, and Borderline Personality Disorder. R1's Social Service progress notes written by V7 (Psychiatric Rehabilitation Services Coordinator/PRSC) dated 4/19/21 at 12:19pm and 5/3/21 at 4:32pm both show that R1 attempted to elope from the facility. On 5/10/21 at 11:58am, V7 stated that R1 did not verbalize any suicidal or homicidal ideations. V7 explained that the two times R1 had attempted to elope, R1 went to other residents' floor and she did not get outside the facility and that R1 likes her daughter, and the elopement attempt was probably to see her daughter. R1's "Screening Assessment for Evaluating Self-Harm/Suicide Risk" dated 2/27/21 shows a score of 4 (minimal or low risk for suicide). On 5/10/21 at 10am, V1 (Administrator) stated that he completed the final investigation on the incident where R1 jumped out the window of the sixth floor dining room, and he didn't know how someone could squeeze her body through the small window opening and no staff member witnessed the incident. V1 explained that all the windows have metal window stoppers that only allow a small opening. V1 added that he took a picture of the window after the incident and that the police officer who came to assess the situation expressed surprise that anyone could go through the opening. V1 stated that he believed the resident climbed the chair, opened the	S9999		

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S9999	Continued From page 3 window, and squeezed her body through the window because R1 weighed only 109 pounds. At this time, V1 presented the facility's initial and final investigation reports dated 5/3/21 and 5/7/21 respectively that were sent to the State's Agency. V1 later presented the picture of the window to the surveyor. On 5/11/21 at 9:50am, V2 (Director of Nursing/DON) stated, "I was the nurse in charge at the time for the resident on the sixth floor, because the nurse (V3/Registered Nurse) would come late for the shift. I was on the floor with two CNAs (Certified Nursing Assistants/V5 and V8). I saw the resident pacing back and forth. I was called to another floor and I left the sixth floor to attend to some other issues as the DON. While I was away from the floor, I heard the code blue called asking all nurses to come down. When I got there, the crash cart was already there and the nurse (V9 Licensed Practical Nurse/LPN) had already started CPR (Cardio-Pulmonary Resuscitation). The paramedics arrived and took over and took the resident to the hospital. The incident happened while I was away to the other floor. After the paramedics took the resident to the hospital, I came inside the building to the sixth floor to see how the whole incident happened. I saw the last window closer to the wall slightly pulled opened, and there was a chair by the window. It didn't open much because of the metal window stopper. I don't know how she managed to squeeze herself into such a small opening. No one brought the resident back into the building. 911 was called immediately." Survey asked V2 why R1 was not placed on a one-to-one monitoring, considering the fact that R1 had attempted to elope earlier on that shift. V2 stated that one-to-one monitoring will make R1 more agitated, but V2 agreed that R1 should have been	S9999		

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monitored more closely. V2 explained that R1 and six other residents (R2, R3, R4, R5, R6 and R7) are on elopement risk. V2 later presented the list of the six other residents at risk for elopement.

On 5/10/21 at 1:40pm, V5 (CNA) stated, "I and the other CNA (V8) were working on the sixth floor. The last time I saw her (R1) was when she was moving around pacing. I went to pass dinner trays. Both of us were watching her and passing trays at the same time. When we didn't find her, we were looking everywhere and then they paged code blue."

On 5/12/21 at 3:20pm, V8 (CNA) stated, "I was working on the sixth floor with V5 (CNA). Earlier in the shift, (R1) was pressing the elevator buttons. The last time I saw her was when she was in her room about 30 minutes before dinner trays came up. No one was assigned to watch her on a one to one. I was at the nursing station and (V5) was passing the dinner trays. The nurse for the floor was (V2) the DON but he got called to another floor."

On 5/11/21 at 1:45pm, V4 (R1's Psychiatric Doctor) was interviewed regarding R1. V4 stated in part, "R1 has diagnoses of Schizophrenia and Major Depression. There could be poor impulse control, agitation, feeling helpless and hopeless. If psychotic, she might be hearing voices. Sometimes, the patient will not show any sign and will be psychotic. The patient could have psychomotor excitement with psychosis and that is when they can do something like what she (R1) did. That is the reason such patients should be in a skilled facility. Depression is treatable but can kill if the patient is not compliant with medications."

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On 5/11/21 at 3:49pm, V10 (R1's Primary Physician) was interviewed. V10 stated, "No one told me she (R1) attempted to elope. I am not the Psychiatrist; I'm the Medical Doctor. If a resident attempted to elope, we have to find out why. Either they don't like the food or they don't just like to be in the facility. If so, then the patient can be discharged to a place they like. If the interdisciplinary team cannot make a decision yet about whether or not to discharge the patient, you can monitor the patient and put them on a locked unit to prevent elopement while trying to make the decision."

R1's Self-Harm Ideation care plan dated 3/3/21 states that R1 has a history of self-harm ideation due to severe mental illness and poor impulse control. Intervention includes in part "As warranted, conduct/carry out daily monitoring and supervision of the resident."

Facility's "Policy and Procedure Regarding Missing Residents and Elopement" dated 5/2011 with latest revision on 1/15/20 documents, "It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk of elopement. All residents assessed to be at risk of elopement will have this issue addressed in their care plan."

(A)