

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145856	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2008
NAME OF PROVIDER OR SUPPLIER ALL FAITH PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 SOUTH GILES AVENUE CHICAGO, IL 60653		
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F 000	INITIAL COMMENTS Complaint Investigation # 0882242/IL35127 no deficiencies 0882284/IL35175 no deficiencies 0882315/IL35204 no deficiencies 0882470/IL35396 no deficiencies 0882529/IL35458 F366 0882580/IL35523 F323 and F490 0882590/IL35548 F323 and F490 0882669/IL35688 F323 and F490	F 000			
F 323 SS=J	An Extended survey was conducted. 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide supervision for one resident R1, who demonstrated and had a history of negative, aggressive, acting out behavior. This failure to intervene with an acute onset of negative, aggressive behavior resulted in R1 hitting his roommate in the head with a clock radio causing R2 to be transferred to the hospital with the diagnosis of acute subdural hematoma with several acute infarctions, (strokes) and currently in a coma.	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>The above facility failure resulted in an Immediate Jeopardy. E7 (Administrator) and E8 (new Director of Nursing) was notified of the Immediate Jeopardy on 6-17-08 at 1:17PM.</p> <p>Findings Include:</p> <p>Observations made on 5-31-08 of R1 and R2's room, there was blood noted on the floor under R2's bed. There was blood saturated in the pillows, on the mattress, on blankets and bedsheets. There was blood on the ceiling above R2's bed and against the wall. This room was locked and no other residents or staff members were allowed in this room per instructions from the local police department.</p> <p>Close record review of R2 is a 77 year old male admitted to the facility on 4-16-08 with the diagnosis which includes advance dementia mixed with Alzheimer's, cerebral vascular accident, peripheral vascular disease and a recent injury to his left shoulder.</p> <p>The facility's incident report dated 5-30-08 reveals R2 was in bed with head of bed elevated 30 degrees. There was left facial swelling, discoloration to left eye with left eye closure. Blood noted on face and gown. Laceration to left cheek and under chin. Pressure applied to lacerations, suctioning to clear airway, radial pulse palpable, 911 called.</p> <p>Phone interview on 6-17-08, Z1 (nurse practitioner/neuro-surgery) told surveyor that R2 was transferred out of the hospital recently and sent to another skilled facility. Z1 also told surveyor the injuries that R2 sustained has changed his life negatively. R2 will never be able</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>to eat again without a gastrostomy tube, he is in a coma, unable to speak, flexion of upper extremities and draw up the lower extremities. This is the extent of his bodily functions. The several strokes R2 had experienced while in the hospital are probably due to the injuries he sustained from the incident in the nursing facility.</p> <p>Interview on 5-31-08, E5 (certified nurse's aide) told surveyor that she open the door to R1 and R2's room and saw R2 lying in his bed with blood draining from it. E5 went on to tell surveyor that as she got closer she saw R2 had a clock radio lying on his face. E5 also told surveyor that before the nurse could apply pressure to stop the bleeding she had to pick parts of the radio out of R1 head. R2 eye was swallow and lacerations of his cheek. There was blood on the pillow and on the night stand. R2 was not talking but his feet was moving. .</p> <p>Interview on 6-2-08 in conference room with E4, (staff nurse) told surveyor that she saw R2 lying in bed facing toward the door. R2's face was swollen and there was blood on his face and gown. There was a clock radio in the bed with R2 . There were broken pieces of sharp plastic on various parts of his face and neck. E4 also told surveyor that once she removed the broken pieces of sharp plastics from on and around R2's face she began to apply pressure to control and stop the bleeding. E4 said that she saw other staff members from the facility, and emergency care was started. EMS (emergency medical service) was called and R2 was transferred to the hospital.</p> <p>Further review of R2's clinical record reveals R2 was totally dependent on staff for all activities of</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>daily living. R2 was unable to ambulate, cloth or feed himself, but verbally able to express his needs.</p> <p>Close record review of R1's clinical record shows R1 is a 50 year old male admitted to the facility on 11-10-07 with the diagnosis of cerebral vascular accident, history of brain aneurysm with left ventricular shunt in brain, multi-infarct with dementia and delirium.</p> <p>Review of R2's admission records dated 11-07 reveals R2 was found in the street wandering around and unable to tell authorities who he was and why he was out along. The consult from a local hospital also states that R2 was confused and had medical problems that attitude to his confusion and disorientation.</p> <p>Review of R1's social service notes dated 5-5-08 reveals R1 experienced periods of altered mental status. R1 became angry with another resident, looking around the unit for him and than scolding him. Scolding him by yelling and screaming and kicking on doors. This occurred 2 to 3 times a week in the past few weeks. There was only one intervention implemented over and over again. The intervention was to walk R1 outside and calm him down. No other interventions were implemented.</p> <p>Social service notes dated 5-28-08 states: R1 became externally agitated this AM. Yelling and cursing at the charge nurse and nurse's aide. The interventions was to walk with resident and give verbal counseling.</p> <p>Interview on 5-31-08, E3 (social service) told surveyor that R1 recently has been having</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>abrupt, agitated behaviors in the past month. This was very unusual for R1 but contributed it the his diagnosis of dementia. E3 also confirmed his social service notes dated 5-5-08 and 5-28-08.</p> <p>Review of R1's physicians notes dated 5-28-08, states: nurse concerned about agitation and sudden out-burst.... Interventions were to continue with psychological evaluation. The psychology evaluation was initiated on 5-28-08, 3 weeks after the negative acting out behavior had began.</p> <p>Interview with E1 and E5 on 5-31-08, both told surveyor immediately after the incident, R1 went to the nurses station and sat down with blood on his hands, clothes and shoes. Both told surveyor that R1 did not realize what he had done.</p> <p>Interview on 6-2-08, Z4 (police detective) Z4 told surveyor that the policemen that answered the call saw R1 sitting on the bench beside the nurse's station with blood on his hands, clothes and shoes. Z4 further went on to tell surveyor that R1 was the obvious person to have attacked R2 because of the blood on his person. Z4 also told surveyor that no one in the facility actual saw R1 attack R2.</p> <p>Phone interview on 6-10-08, Z5, (psychologist) told surveyor that he was only informed of R1's agitation once by the facility and did not know if it was related to medical concerns or just behavioral problems. This is why R1 was transferred out of the facility to the hospital.</p> <p>Phone interview on 6-6-08 Z6 (medical attending) told surveyor that no one from the facility notified</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>him at all of R1's behavior and he did not know of any incidents in the facility.</p> <p>Interview on 6-10-08 E2 (Administrator) E2 told surveyor that she was unaware of R1's acting out behaviors and if she would have known she would have intervened.</p> <p>While the immediacy was removed on 6-17-08 the facility remained out of compliance at a Severity Level 2 in order to evaluated training and changes put in place to address identified problems.</p> <p>The surveyor confirmed that the facility took the following actions to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> 1). The facility removed R1 from the facility immediately on 5-30-08 by the local police. 2). All of the residents on the Alzheimer's unit were reassessed for potential risk of aggressive behavior. 3). All residents triggering at risk for potential aggressive behavior have had their care plan modified to reflect new monitoring policy. 4). New Policy and Procedures for Dementia residents identified at risk for aggression. 5). New Policy and Procedures for Dementia Residents who display aggressive behavior. 6). All staff have been in-serviced on new policy. 7). Monitor for 72 hours for aggressive behavior with residents that have been triggers for 	F 323			

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F 323	Continued From page 6 negative behavior.	F 323			
F 366 SS=C	<p>8). Initiate aggression Care Plan.</p> <p>9). Notify staff, physician and family if behavior escalates.</p> <p>10). Administer medications as ordered and monitor for effectiveness of medication.</p> <p>11).. Get psychological evaluation.</p> <p>12). QA meetings to evaluate the behavior of residents with negative acting out behaviors.</p> <p>483.35(d)(4) FOOD</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve a variety of foods for the breakfast meals.</p> <p>Findings include:</p> <p>Observations of the breakfast meal of 6-5-08, surveyor observed on the entire first floor, all residents were served oatmeal. Review of the dietary cycle menu for the summer, oatmeal is on the menu for breakfast everyday.</p> <p>Interview with E5 (nurse's aide), on 6-5-08 at 2:00PM, E5 stated that everyday the kitchen serves oatmeal to the residents. No matter what is on the menu for the breakfast, we serve</p>	F 366			

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F 366	Continued From page 7 oatmeal. I know we serve it because I take the meal up to the floors everyday.	F 366			
F 490 SS=J	<p>Interview with E6 (food service supervisor), on 6-5-08 at 2:30PM, E6 stated that she was new at the facility. E6 also stated that she does not like the company that the facility has a contract with because of the lack of variety in meals. E6 further went on to state that she is in the process of revising the menu for the facility's residents.</p> <p>483.75 ADMINISTRATION</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide effective administrative services to effectively and efficiently use its resources. To prevent one sampled resident, R1 from life threaten injuries,(coma, altered feeding patterns, and multiple strokes) from a physical assault from another resident, (R2) who displayed aggressive negative acting out behaviors for the pass month.</p> <p>The above facility failure resulted in an Immediate Jeopardy. E7(Administrator), and E8(new Director of Nursing) was notified on the Immediate Jeopardy on 6-17-08 at 1:17PM.</p> <p>Findings include:</p> <p>Observations made on 5-31-08 of R1 and R2's</p>	F 490			

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F 490	<p>Continued From page 8</p> <p>room, there was blood noted on the floor under R2's bed. There was blood saturated in the pillows, on the mattress, on blankets and bedsheets. There was blood on the ceiling above R2's bed and against the wall. This room was locked and no other residents or staff members were allowed in this room per instructions from the local police department.</p> <p>Closed record review of R2 is a 77 year old male admitted to the facility on 4-16-08 with the diagnosis that includes advanced dementia mixed with Alzheimer's, cerebral vascular accident, peripheral vascular disease and a recent injury to his left shoulder.</p> <p>The facility's incident report dated 5-30-08 reveals R2 was in bed with head of bed elevated 30 degrees. There was left facial swelling, discoloration to left eye with left eye closure. Blood noted on face and gown. Laceration to left cheek and under chin. Pressure applied to lacerations, suctioning to clear airway, radial pulse palpable, 911 called.</p> <p>Phone interview on 6-17-08, Z1 (nurse practitioner/neuro-surgery) stated that R2 was transferred out of the hospital recently and sent to another skilled facility. Z1 also stated that the injuries R2 sustained has changed his life negatively. R2 will never be able to eat again without a gastrostomy tube, he is in a coma, unable to speak, flexion of upper extremities and draws up the lower extremities. This is the extent of his bodily functions. The several strokes R2 had experienced while in the hospital are probably due to the injuries he sustained from the incident in the nursing facility.</p>	F 490			

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F 490	<p>Continued From page 9</p> <p>Interview on 5-31-08, E5 (certified nurse's aide) stated that she opened the door to R1 and R2's room and saw R2 lying in his bed with blood draining from it. E5 went on to say that as she got closer, she saw R2 had a clock radio lying on his face. E5 also stated that before the nurse could apply pressure to stop the bleeding she had to pick parts of the radio out of R1 head. R2's eye was swollen and had lacerations on his cheek. There was blood on the pillow and on the night stand. R2 was not talking, but his feet was moving.</p> <p>Interview on 6-2-08 in conference room with E4 (staff nurse) stated that she saw R2 lying in bed facing the door. R2's face was swollen and there was blood on his face and gown. There was a clock radio in the bed with R2. There were broken pieces of sharp plastic on various parts of his face and neck. E4 also stated that once she removed the broken pieces of sharp plastic from, on and around R2's face she began to apply pressure to control and stop the bleeding. E4 said that she saw other staff members from the facility and emergency care was started. EMS (emergency medical service) was called and R2 was transferred to the hospital.</p> <p>Further review of R2's clinical record reveals R2 was totally dependent on staff for all activities of daily living. R2 was unable to ambulate, cloth or feed himself, but verbally able to express his needs.</p> <p>Closed record review of R1's clinical record shows R1 is a 50 year old male admitted to the facility on 11-10-07 with the diagnosis of cerebral vascular accident, history of brain aneurysm with left ventricular shunt in brain, multi-infarct with</p>	F 490			

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F 490	<p>Continued From page 10 dementia and delirium.</p> <p>Review of R2's admission records dated 11-07 reveals R2 was found in the street wandering around and unable to tell authorities who he was and why he was out alone. The consult from a local hospital also states that R2 was confused and had medical problems that attributed to his confusion and disorientation.</p> <p>Review of R1's social service notes dated 5-5-08 reveals R1 experienced periods of altered mental status. R1 became angry with another resident, looking around the unit for him and than scolding him. Scolding him by yelling and screaming and kicking on doors. This occurred two to three times a week in the past few weeks. There was only one intervention implemented over and over again. The intervention was to walk R1 outside and calm him down. No other interventions were implemented.</p> <p>Social service notes dated 5-28-08 indicated that R1 became externally agitated this AM. yelling and cursing at the charge nurse and nurse's aide. The intervention was to walk with resident and give verbal counseling.</p> <p>Interview on 5-31-08, E3 (social service) stated that R1 recently had been having abrupt, agitated behaviors in the past month. This was very unusual for R1, but contributed it to his diagnosis of dementia. E3 also confirmed his social service notes dated 5-5-08 and 5-28-08.</p> <p>Review of R1's physicians notes dated 5-28-08, states: nurse concerned about agitation and sudden out-burst..... Interventions were to continue with psychological evaluation. The</p>	F 490			

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F 490	<p>Continued From page 11</p> <p>psychology evaluation was initiated on 5-28-08, three weeks after the negative acting out behavior had began.</p> <p>Interview with E1 and E5 on 5-31-08, both stated that immediately after the incident, R1 went to the nurses station and sat down with blood on his hands, clothes and shoes. Both stated that R1 did not realize what he had done.</p> <p>Interview on 6-2-08, Z4 (police detective) Z4 stated that the policemen that answered the call saw R1 sitting on the bench beside the nurse's station with blood on his hands, clothes and shoes. Z4 further went on to stated that R1 was the obvious person to have attacked R2 because of the blood on his person. Z4 also stated that no one in the facility actually saw R1 attack R2.</p> <p>Phone interview on 6-10-08, Z5 (psychologist) stated that he was only informed of R1's agitation once by the facility and did not know if it was related to medical concerns or just behavioral problems. This is why R1 was transferred out of the facility to the hospital.</p> <p>Phone interview on 6-6-08 Z6 (medical attending) stated that no one from the facility notified him at all of R1's behavior and he did not know of any incidents in the facility.</p> <p>Interview on 6-10-08, E2 (Administrator) stated that she was unaware of R1's acting out behaviors and if she would have known she would have intervened.</p> <p>While the immediacy was removed on 6-17-08, the facility remained out of compliance at a Severity Level 2 in order to evaluated training</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145856	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2008
NAME OF PROVIDER OR SUPPLIER ALL FAITH PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 SOUTH GILES AVENUE CHICAGO, IL 60653		
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F 490	<p>Continued From page 12 and changes put in place to address identified problems.</p> <p>The surveyor confirmed that the facility took the following actions to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> 1). New Administrator in facility 2). New Administrator has implemented new policies dealing with identification and assessments of Dementia residents at risk for potential behavior. 3). These new policies will be overseen by the Dementia coordinator. 4). In-service on new policies and procedures to staff on dealing with Dementia resident with aggressive behavior. 5). New Administrator will monitor compliance of the new Dementia policies. 6). QA committee will do chart audits, rounds and staff meeting to monitor compliance. 	F 490			