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
	IL6007140	A. BUILDING: _____ B. WING _____	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE VILLAGE NRSG & RHB CTR	2320 SOUTH LAWNDALE CHICAGO, IL 60623

(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 Annual Certification Survey Complaint Investigation #1887060 / IL106910 - no findings #1886163 / IL105911 - F657, F689 #1884124 / IL103673 - no findings #1883787 / IL103304 - no findings #1883581 / IL103092 - F609, F610 #1883377 / IL102873 - no findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1)6) 300.3240a) (1 OF 1) 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.	S9999	Attachment A Statement of Licensure Violations	

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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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
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 EVIDENCED BY:

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Based on interview, and record review, the facility failed to develop and implement appropriate measures to ensure adequate supervision for one resident (R145) in the sample of 21 reviewed for supervision and death. This failure affected R145 who expired in the facility with cause of death identified as Combined Drug (Heroin, Fentanyl, Acetyl Fentanyl, and Lorezepam) Toxicity.

Findings include:

On 11/6/18, review of R145's medical record Face Sheet showed that R145 was last admitted 2/16/18 with diagnosis that includes but not limited to Paranoid Schizophrenia, Major Depressive Disorder, Violent behavior, Muscle Weakness, Lack of Coordination and Iron deficiency. R145 expired on 7/4/18 at the facility. Review of R145's State Certificate of Death listed Cause of Death as "Combined Drug (Heroin, Fentanyl, Acetyl Fentanyl, Lorezepam) Toxicity."

On 11/07/18 at approximately 9:22am, V4 PRSD (Psychiatrist Rehabilitation Services Director) stated R145 was on supervised pass to the community at the time of death. V4 explained that if a resident has an independent community pass they sign in and out at the front desk and if it is a supervised pass the family, or the staff accompanying resident out will sign in and out.

V4 was unable to present any record where R145 was signed out on 7/3/18. V4 presented R145's independent Pass sign out that showed that R145 was signed out with supervision on 4/3, 5/1, 5/26 and on 5/31 R145 signed (R145) out independently to the park. V4 identified the signed sheet as 4/3/18, 5/1/18, 5/26/18 and 5/31/18 stating those are for this year. V4

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explained that she is new to the facility but to her knowledge R145 should not be signing (R145) out by himself because R145 is on supervised community pass.

On 11/7/18 at approximately 10:47am, V6 LPN (Licensed Practical Nurse) was stated on 7/4/18 while making the rounds V12 CNA (Certified Nurse's Aide) called that R145 was not responsive and CPR (Cardiac Pulmonary Resuscitation) was initiated and emergency line called. V6 stated R145 was pronounced dead by the paramedics.V4 stated in part that (V4) could not remember on 7/3/18 during the day shift 7am to 3pm whether R145 went out.
On 11/17/18 at approximately 11:18am, V12 stated that on 7/4/18 while making round in the morning shift R145 was noted in bed face down. V12 stated on 7/3/18 R145 seems quite and stayed to self. V12 stated (R145) did not go out that day on community pass. V12 further explained that (R145) is on restriction pass which means R145 can only go out with family and supervision.

On 11/7/18, V23 LPN acknowledged she worked on 7/3/18 on 3-11 shift and there was no unusual occurrences happenings on the shift. V23 stated were interviewed and they all stated they were. Review of R145 medical record MAR (Medication Administration Record) for 7/01/2018 to 7/31/2018 did not show that 9:00pm scheduled medications that includes but not limited to Atorvastatin 40mg (Milligram) tablet and Olanzapine 15mg tablet were not administered. No documentation presented to show why R145 did not take the medicine.

On 11/7/18 and 11/18/18 the facility was unable to provide any documentation that showed why

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R145 did receive 9:00pm Atorvastatin and olanzapine medications.

V3 ADON (Assistance Director of Nurses) identified V24 RN (Registered Nurse) has the nurse who was schedule and worked with R145 on 7/3/4 11pm to 7/4/18 7am. V3 then stated but V24 is no longer working with the facility. V3 explained that V24 has been terminated.

Review of V24 personal file showed that on 7/3/18 night shift, V22 was terminated for failures to monitor CNA rounds, rounds not done, round shift form not accurate, and not responding when told that a resident suffered injury.

On 11/6/18, V4 PRSD (Psychiatrist Rehabilitation Services Director) stated the PRSC (Psychiatrist couseling done for R145. V21 (PRSC) assigned to R145 last day of work was 5/11/18. V4 (PRSD) was unable to show any documentation that R145 went out of the facility from 7/1/18 to 7/3/18. And no documentation of R145 being noted to be missing in the facility on 7/3/18 before expiration.

On 11/7/18, V4 presented a note with no facility letter heading dated 11/07/2018 that pointed out that "No July 1st -July 4th supervised community pass was used for following days.

On 11/7/18 at V12 (CAN) V6 and V23 (LPN)'s stated the rounds are made every two hours. The facility was unable to present any rounds documentation for 7/3/18.

The facility policy titled Resident Community Access with revised date 5/2018 pointed out in part that the facility would like all residents who wish to go out to the community to be as safe as possible. Under policy interpretation and

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S9999	Continued From page 5 implementation the policy further documented in part that residents who have been approved for pass privileges must sign in and out of the facility. The facility Medication/ Treatment Administration policy with no effective date stated pointed out that it is the facility policy that each medication/treatment administered will be promptly documented in the medication record after administration. The facility Nurse Staff Rounding policy with no date pointed out that it is the policy of this facility for nursing staff to monitor the well-being of residents on at two hour intervals and as needed. The policy listed procedure to be followed that includes but not limited to if resident is not found the building must be searched, surrounding are searched, management, families and authorities notified. The facility Job description on (LPN) and RN with no date pointed out to closely monitor and supervise all facility residents per facility policies and as warranted by good nursing judgment. To ensure that appropriate documentation/ charting is completed as required and in accordance with established policies and procedure. (A)	S9999		