STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009872	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST CHICAGO TERRACE NH	928 JOLIET ROAD WEST CHICAGO, IL 60185

(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
S9999	Final Observations Statement of Licensure Violatations Section 300:690b)c) Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purpose of this section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free compliant registry hotline. The facility shall send a narrative summary of each reportable incident to the Department within seven days after the occurrence. This requirement was not met as evidenced by: Based on record review and interview, the facility failed to notify State Agency of serious incidents involving residents. This applies to two residents of nine residents (R10, R15) reviewed for behavior in the sample of 23.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009872	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST CHICAGO TERRACE NH	928 JOLIET ROAD WEST CHICAGO, IL 60185

(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
S9999	Continued From page 1	S9999		

The findings include:

1. R15's initial nurse's notes, show R15 was admitted to facility on July 10, 2015 from hospital with diagnoses of major depression, and non-dependent alcohol abuse. Hospital physician history and physical dated July 5, 2015 showed R15 had been hospitalized for stabilization and monitoring in behavioral unit for alcohol abuse and suicidal ideation.

R15's Suicidal/Self Harm Assessment form dated 7/12/15 showed R15 as having recurrent thoughts of wishing for death, and history of suicidal attempts. Documental recommendations and outcome assessment included "Resident is a new admit and has a history of suicidal ideation ,will continue to monitor."

Progress notes of July 20, 2015 at 2:30 PM showed R15 had been counseled by E8 (PRSD) Psychiatric Rehabilitation Service Director for consuming alcohol on July 18 and July 19, 2015 while in the facility. E8 stated on July 30, 2015 at 12:00 PM, at the time R15 did not appear intoxicated during the meeting.

Progress notes of July 20, 2015 at 6:00 PM showed R15 was approaching dining area without pants on and blood on her wrist. R15 stated she used a blade from a makeup sharpener to cut her wrist because she wanted to end her life. Progress notes showed
that 911 was called and R15 was transferred to hospital.

Facility Post Incident Documentation of July 20, 2015 at 11:37 PM, showed R15 was found to have cuts on both arms, two lines in each arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009872	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST CHICAGO TERRACE NH	928 JOLIET ROAD WEST CHICAGO, IL 60185

(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
S9999	Continued From page 2	S9999		

measuring approximately 12 (cm) centimeters long. Noted to have large amount of blood in tub. Documentation shows R15's physician and family were notified of incident. There is no documentation that IDPH was notified of incident of R15.

On July 28, 2015 at 1:30 PM E1, Administrator stated she was informed by her consultant IDPH did not have to be notified because it was not considered "serious". On July 28th, 2015 and July 29th, 2015 E1 was requested for the facility's "Incident Reporting Policy". The facility did not provide the policy.

2) R10 was admitted on April 14, 2015 with multiple medical conditions including paranoid schizophrenia, depressive disorder NEC (not elsewhere classified), hypertension, and esophageal reflux.

The incident report dated July 5, 2015 at 11:34 PM showed R10 reported to staff he was hearing voices and angels were beside him telling him to hurt someone. Staff was with R10 on a one to one monitoring when R10 went to his bathroom and punched the mirror. R10 sustained laceration to back of his right hand. R10 was sent to the hospital.

On July 29, 2015 at 9:15 AM, E2 (Director of Nursing/DON) stated staff reported to her on July 5, 2015 R10 was having auditory hallucinations with voices telling him to hurt someone. E2 said she instructed staff to place R10 on a one to one monitoring. Staff was in the room with R10 when he went to the bathroom and punched the mirror in the bathroom. R10's hand was bleeding. The physician was notified of the hallucination prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009872	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST CHICAGO TERRACE NH	928 JOLIET ROAD WEST CHICAGO, IL 60185

(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
S9999	Continued From page 3 the incident. R10 was sent to the hospital and was admitted. The family member was notified. R10 returned to the facility on July 13, 2015. E2 said she did not know if the incident was reported to the state survey agency. On July 29, 2015 at 9:35 AM, E1 (Administrator) stated she did not report the incident to the Illinois Department of Public Health (IDPH). (C)	S9999		