STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146164	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY CARE CENTER	**4314 SOUTH WABASH AVENUE CHICAGO, IL 60653**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to accommodate the needs and preferences of 1 (R11) resident out of 5 residents reviewed for accommodation of needs. Findings include: On 08/21/2020 at 10:23 AM, surveyor was standing in the hall when R11 loudly stated Hey! V23 (Activity Aide) entered R11's room and stated Do you want to get dressed to smoke? R11 replied yeah. V23 left R11's room and walked towards the nursing station. At 10:24 AM, surveyor asked R11 how are you doing? R11 stated Come on man. Come on. R11 lifted a pair of jeans with a belt and repeated Come on man. Come on. R11 was lying in bed wearing a black long sleeve shirt and an incontinence product. Surveyor asked R11 orientation questions. R11 repeated Come on man, shook head, and stated Get out of here. Can't believe this. Surveyor left the room and stood in the hallway outside R11's room. At 10:33 AM, R11 called out Hey! At 10:35 AM, R11 called out Hey! Come on man. At 10:38 AM, R11 called out Hey! At 10:39 AM, V15 (CNA, Certified Nursing Assistant) walked towards R11's room with linen cart. V15 stated (V15) is the only CNA on the floor. V15 placed the linen cart in front of R11's room and walked back towards the nurses' station. At 10:40 AM, R11 called out Hey! V15 went into R11's room at 10:41 AM. V15 stated oh you want to get dressed so you can smoke? R11 replied yeah. V15 then stated Do you want to put on new clothes? You wore those pants yesterday. Those are dirty. R11 replied No come on man. Come on. V15 encouraged R11 to put on new pants but R11 refused. V15 walked out of the room. At 10:42 AM, V15 stated (V15) was going to tell the nurse and social services. At 10:49 AM, V23 stated R11 has been screaming to get up since 10:00 AM. At 10:54 AM, V3 (Social Services Director) went into R11's room. V3 looked for clean pants for R11 to wear. At 10:58 AM, V25 (Psychiatric Rehabilitation Services Coordinator) walked into R11's room and stated (R11) what's wrong? You didn't get to smoke this morning huh? V25 stated (R11) likes to get up early in the morning. (R11) likes to sleep early and get up early. If (R11) doesn't get to smoke, this is what (R11) do. V3 and V15 proceeded to help dress R11. On 08/25/2020 at 11:07 AM, record review of R11's care plan reads R11 requires assistance from staff in the area of personal grooming related to [MEDICAL CONDITION] and poor coordination. Interventions include staff providing R11 with hands on assistance as needed and staff will assist R11 during grooming. R11 is also care planned for activities of daily living self-care performance deficit related to fatigue, limited mobility, and limited range of motion. Interventions stated R11 is dependent on staff for dressing and requires extensive staff assist to slide onto (R11's) wheelchair.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations, interviews and record reviews, the facility failed to provide clean linens for 5 residents (R2, R12, R13, R14, R15) of 7 residents investigated for lack of supplies. Findings include: On 08/20/20 surveyor observed R2's bed disheveled, filthy sheets, no pillow case from 10:00 am to 01:15 pm. On 08/21/20 at 12:4 pm, 5 Observed R12's bed disheveled with dark blanket and a dirty sheet under the blanket. R12 States, they have not changed my bed today. I don't know why. Sometimes they don't change it. On 08/21/20 at 12:50 pm observed R13, R14 and R15's beds with no bed sheets on. Residents out of their beds. On 08/20/20 at 12:23 pm V17(certified nurse Aide) states sometimes they don't have soap and deodorant. It happened a couple months ago. We don't have enough towels. We have told the supervisor, the manager and they don't do nothing. We complained verbally. We did not document it. We tell the housekeeping manager, but he can't do much because there is not enough housekeeping to keep the linens and towels washed. Sometimes we have to cut the towels to cover all residents. Sometimes there is no CNA on the night shift and the residents are left in urine and the smell is so strong that I had to buy strong soap and deodorant to clean the residents. I don't remember for which resident I did. I did it twice. Usually if there is nothing in the closet, we tell the supervisor or DON and they go downstairs to get it. It has not happened in while, but the linen and towels has been always an issue, except for today. On 08/21/20 at 9:22 am asked why R2 didn't have his bed linen changed, why he had no pillowcase on 8/20/20 during the morning shift. V17 (CNA) states Sometimes they don't have enough pillowcases and we need to use a sheet to cover the pillow. Either because the pillowcases are dirty, or were not brought to the floors because they don't have enough housekeepers working in the laundry. On 08/21/20 at 09:30 am V20 (Laundry Aide) states I gave to the 1st and the 3rd floor this morning 15 flat sheets, 15 hand towels, 5 body towels, 10 wash clothes. To the 2nd floor I gave 25 flat sheets, 25 fitted sheets, 20 pads, 25 wash clothes and 5 body towels. On 08/21/20 at 12:50 pm V15(CNA) states I've got 20ish flat sheets and towels and I have 58 residents on this floor. We are supposed to change their beds every morning, but I don't have enough sheets. I did not have time to change because I am by myself and don't have enough bed linen to do it. Observed V15 passing lunch trays at this time. 08/21/20 facility's Census documents: 3rd floor 58 residents; 2nd floor 43 residents; 1st floor 40 residents On 08/21/20 at 12:59pm V2 (Director of Nursing) states We don't have a policy on linen change. On interview V2 and V21 (Assistant Administrator) state that the inventory should be 3 sets of linen/towels per resident. On 08/25/20 at 10:16 am V26 (Housekeping Director) states We don't have enough linen to serve the residents necessity. We distribute it as much as we can, but right now , based on the census, it wouldn't be enough.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to prevent the occurrence of verbal abuse for 2 residents (R6, R7) of 4 residents investigated for verbal abuse. Findings include: Facility investigation records shows that V39 (Certified Nurse Aide) verbally abused R6 and R7 on 06/21/2020. The final report conclusion reads: E1, now V39 exhibited unusual, and inappropriate behavior on the floor during his interaction with residents on this day. This behavior is unacceptable and the employee will be released from his duty with the facility. V1 (Administrator), V9 (Wound Care Nurse), , V40 (LPN) and V41(Restorative Aide) were interviewed regarding the allegation of verbal abuse involving R6 and R7. They all confirmed that the abuse did happen. On 08/26/20 at 03:35 pm V40 states The first time V39 did that to R7, I told him, you should not be verbally abusive to the resident, then while I was calling V9, V39 started being aggressive and having a confrontation with R6. R6 usually would get pretty upset when he was confronted, so he was very angry. They both, V39 and R6 were very confrontational. On 08/26/20 at 04:11 pm V41 states R6 was my patient. I did medicated him after the incident. After V39's removal from the floor, R6 asked to be medicated. I can't remember the medication, but it was his as needed medication. He did have an as needed order. Investigation statements reviewed and V9's witness statement form documents that V39 refused to give his urine sample to be tested . On her statement V9 says the CNA (V39) behavior was

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) very abnormal. He was irate. He was informed that he couldn't use profanity toward co-workers and the residents. Writer (V9) ask V39 to take a urine test due his odd behavior, he stated I am not taken no f** urine test. I am going to punch out and go home. Reviewed facility policy titled Abuse Program Prevention dated 02/2017. Reads: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of [REDACTED]. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED].
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure an emergency crash cart was fully stocked during a code blue and failed to ensure an emergency crash cart was fully stocked at the beginning of the shift. This affected 1 (R3)vout of 1 residents reviewed for code blue and has a potential to affect the 58 residents that reside on the 3rd floor out of the 142 residents at the facility. Findings include: On 08/20/2020 at 11:41 AM, V10 (Nurse) was working on the third floor and sitting at the nurses' station. V10 stated there were 58 residents on the floor. Surveyor observed the crash cart without a pin and the locking mechanism pulled out. V10 stated the crash cart is supposed to be locked at all times. V10 stated the crash cart was already unlocked at the start of the shift. Crash Cart Checklist was hanging on IV (Intravenous) pole of crash cart. Writing at the bottom of the Crash Cart Checklist reads Need Restocking with date of 8/17/20. Surveyor reviewed the crash cart with V10 using the Crash Cart Checklist. Missing items on the crash cart included 1 gallon of distilled water, 5 5ml (milliliter) syringes, 1 [MEDICATION NAME] injection kit and 2 50ml of 50% [MEDICATION NAME]. V10 stated (V10) was not aware these items were missing. V10 stated this would be an issue if there was an emergency because it's not properly stocked. On 08/20/2020 at 12:24 PM, V2 (Director of Nursing) stated if a crash cart is open then it was used. V2 stated the crash cart should be restocked within 24 hours from when it was used. After it is stocked, staff are supposed to lock it with the red lock. At 2:15 PM, V2 stated the crash cart should be full at the start of the shift. On 08/25/2020 at 10:03 AM, V13 (Nurse) stated a code blue was called for R3 on 08/16/2020. V13 stated the second floor crash cart was not stocked at the time of the code blue. On 08/25/2020 at 12:21 PM, V29 (Nurse) stated the crash cart was not fully stocked during R3's code blue. V29 stated the face mask attachment for the bag valve mask was missing. V29 stated the face mask is used to seal around a patient's mouth and nose to ensure oxygen goes inside the body. Record review of the second floor's Crash Cart Check List reads the crash cart was unlocked on 08/15/2020 during the morning, afternoon and night shift prior to R3's code blue. At the bottom of the Crash Cart Check List reads: - EVERY SHIFT SUPERVISOR AND/OR NURSE MUST SIGN THAT CRASH CART IS LOCKED. - IF CRASH CART IS UNLOCKED CART MUST BE AUDITED FOR MISSING ITEM. - IF AN ITEM IS REMOVED FROM CRASH CART PLEASE WRITE DOWN THAT HAS TO BE REMOVED AND WHY. THIS WILL ENSURE THAT WE CAN REPLACE MISSING ITEM W/O (without) AUDITING ENTIRE CART. On 08/26/2020 at 04:14 PM, V35 (Nursing Supervisor) stated every nurse is responsible for checking the crash cart each shift. V35 stated items used or missing are supposed to be replaced. V35 stated after it is filled, (V35) places a red lock on it. V35 states nurses are not supposed to break the red lock unless it is an emergency. Facility policy titled Code Blue effective 04/2020 reads: 3. An ambu bag and backboard will be kept on each of the emergency carts. 7. The cart will be restocked as needed by the responsible RN (Registered Nurse) at designated stations.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide adequate staffing to accommodate the needs and preferences for 2 (R5 and R11) residents and has the potential to affect the remaining 39 residents on the first floor and the remaining 57 residents on the third floor out of the 142 residents in the facility reviewed for staffing. Findings include: On 08/21/2020, Nursing Daily Staffing sheet reads 1 CNA for the third floor. At 10:23 AM, surveyor was standing in the hall when R11 loudly stated Hey! V23 (Activity Aide) entered R11's room and stated Do you want to get dressed to smoke? R11 replied yeah. V23 left R11's room and walked towards the nursing station. At 10:33 AM, R11 called out Hey! At 10:35 AM, R11 called out Hey! Come on man. At 10:38 AM, R11 called out Hey! At 10:39 AM, V15 (CNA, Certified Nursing Assistant) walked towards R11's room with linen cart. V15 stated (V15) is the only CNA on the floor and is currently doing morning rounds. At 10:42 AM, V15 stated there are 7 residents on the third floor that need assistance to be changed. V15 stated so far (V15) has changed 3 residents and has 3 or 4 more residents to change. At 10:49 AM, V23 stated R11 has been screaming to get up since 10:00 AM. V23 stated R5 has not gotten up because the floor is short staffed. At 10:54 AM, V3 (Social Services Director) and V15 to assisted R11 get dressed and up into the wheelchair. Record review of R11's care plan reads R11 requires assistance from staff in the area of personal grooming related to [MEDICAL CONDITION] and poor coordination. Interventions include staff providing R11 with hands on assistance as needed and staff will assist R11 during grooming. R11 is also care planned for activities of daily living self-care performance deficit related to fatigue, limited mobility, and limited range of motion. Interventions stated R11 is dependent on staff for dressing and requires extensive staff assist to slide onto (R11's) wheelchair. On 08/25/2020, Nursing Daily Staffing sheet reads 1 CNA for the first floor. On 08/25/2020 at 11:32 AM, R5 was asleep in bed. Bed sheet had a tan stain near R5's upper body. There was a black flying insect flying around R5's head. 3 blue diapers with brown stains on the cotton side laid on the floor near the dresser. On 08/25/2020 at 11:32 AM, V19 (CNA) stated (V19) was the only CNA taking care of the 40 residents on the first floor. V19 stated feeling overworked and overwhelmed. V19 stated (V19) has not done rounds on R5 yet. V19 stated if (V19) had additional help, R5 would have clean linen and no diapers laying on the floor. On 08/25/2020 at 1:19 PM, V30 (Staffing Coordinator) stated there should be 2 CNAs on the first floor and on the third floor for every shift. On 8/23/20 at approximately 10:43am on 3rd floor during tour of unit, V42, (restorative aide) stated, I have the whole floor, close to 60 residents. Honestly, it is like this a lot of times. Whenever they are short I go to that floor. I can rarely do my job because of floor assignment. I should be doing monthly weights for facility, shaving residents, range of motion, it just won't get done. When I am the only CNA on the floor, I am unable to do my work. Weights just don't get done. Should have more CNA's. I do my best. Asked V11, (LPN) for copy of 3rd floor nursing assignment sheet. V11, (LPN) stated I am not sure what happened to assignment sheet. It was taped up here. I can write up a new one. There are 58 residents. I have residents 315 to 328, and V44, (LPN) has residents 301 - 314. Surveyor inquired how many CNAs for the 58 residents on the floor? V11, (LPN) stated 58, we only have 1 CNA for the residents. Initial assignment sheet given to surveyor showed V43 (CNA) assigned to residents in 301-314 and V42, (CNA) assigned to 301-328. Surveyor identified all staff working on 3rd floor and V43 (CNA) not working on 3rd floor. V11, (LPN) stated, V43, (CNA) is not here, he was scheduled. V11, proceeded to write nursing staff next to nursing assistant assignment. Again surveyor asked V42, (restorative aide), how many residents she was assigned to care for? V42, (CNA) stated, I have the whole floor about 60 residents. 3rd floor midnight census sheet for 8/23/2020 lists 58 residents. On 8/23/2020 at approximately 11:10am surveyor inquired about call light being answered, needs met, and staffing. R16 stated I am tired of dealing with them (referring to nurses). They do not come when you put light on. The staff is messed up. Don't have enough people. Do not honor request. They (staff) gossip and talk about people. V17 stated they, don't come when you call, they do what they want to do. I speak up for him (referring to roommate) he cannot walk so I have to go get them (staff). DON knew before she left.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observations, interviews and record reviews, the facility failed to maintain an effective pest control program affecting 1 (R5) out of 8 residents reviewed for physical environment. Findings include: On 08/20/2020 at 10:52 AM, R5 was

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F 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) sitting in (R5's) wheelchair in (R5's) room. Surveyor observed a black flying insect on R5's right shoulder. There was an additional black flying insect on R5's bedside table and another black flying insect on R5's pillow. R5 stated them flies are always here. On 08/20/2020 at 11:02 AM, V5 (Housekeeping) was mopping R5's floor. Surveyor pointed out the flying insects and V5 stated yeah them flies. That's been a problem. V5 also stated Every time I come this way there's usually flies. On 08/20/2020 at 12:43 PM, R5 was sitting up in (R5's) wheelchair and eating pudding. Black flying insect flew around R5 and landed on R5's right shoulder. On 08/21/2020 at 10:10 AM, R5 was sitting up in the wheelchair while V17 (Certified Nursing Assistant) changed R5's bed linens. R5 was eating rice crispy treat and drinking coffee. Black flying insect landed on R5's pillow. V17 waved a hand towards the insect and the insect flew around R5's head. On 08/25/2020 at 10:25 AM, R5 was asleep in bed. Black flying insect was flying around R5's head. Facility policy titled Pest Control effective 04/2020 reads: This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.