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	14E506	A. BUILDING ______ B. WING ______	05/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	**7325 SOUTH EXCHANGE CHICAGO, IL 60649**

(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) COMPLETION DATE
F 490	Continued From page 52 observations during the survey where residents were smoking in bed or smoking in other undesignated areas of the facility. Review of the facility's policy and procedures for abuse, smoking and employee handbook indicates that facility staff are not following or are not aware of these policies and procedures. The facility remains out of complaince at a severity level II in order to allow implementation of the facility plan of correction for F490 and time for the facility to evaluate efficacy of the interventions. The survey team confirmed that the facility took the following actions to remove it: -An in-service for facility administration has been completed. In addition to the training, several facility-wide system changes have been implemented to address issues of proper investigation, supervision and employee screening. An in-service was completed with the Administrator, PRSD, DON and ADON. An additional in-service was completed with the Administrator on May 23, 2008. -A "Staff Debriefing Strategies" process has been implemented -The administrator is in the process of creating Interdisciplinary Crisis Teams to respond to emergency situations rather that utilizing Security staff for all emergency interventions -A Help Request Form has been developed to assist with identifying complaints	F 490		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 53 LICENSURE VIOLATIONS 300.610a) 300.1210b)6) 300.3240a) 300.3240b) 300.3240e) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) 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 b) A facility employee or agent who becomes	F9999		

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F9999	Continued From page 54 aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These regulations are not met, asevidenced by the following: Based on observation, record review and interviews, the facility failed to initiate an abuse investigation for 5 of 27 residents in the sample (R6, R11, R15, R20 and R25) and for 1 resident outside the sample (R28), with allegations of staff-to-resident physical abuse, resident-to-resident physical abuse and resident-to-resident sexual abuse. The facility also failed to ensure that one resident (R15) was free from possible sexual abuse by a male resident with a history of inappropriate sexual	F9999		

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behavior toward women as well as physical abuse from other female residents.

Findings include:

1. R11 is a 50 year old resident who was admitted to the facility with diagnoses including schizoaffective disorder, chronic obstructive pulmonary disease and chronic pancreatitis. According to the most recent resident assessment instrument dated 3/27/08, facility staff identified that R11 has moderately impaired cognitive skills for decision making; and difficulties with long and short term memory recall.

According to an article which appeared in a local newspaper on 5/7/08, there was a fire in the facility on 5/6/08 which required the services of the fire department. Upon entrance into the facility on 5/12/08, state surveyors requested that facility staff present the reportable and non-reportable accident/incident reports for a period of 6 months. The facility presented the documents as requested. However, there was no report of the fire incident of 5/6/08. During an interview on 5/12/08, E1 (administrator) stated that an incident report for the fire of 5/6/08 was completed and that she had the supporting documentation and would present that information. After surveyor prompting, E1 presented the documentation.

E1 presented a typewritten summary of the events related to the fire incident of 5/6/08. There was no documentation to support that facility staff initiated an investigation to determine the cause of the fire. There was no documentation supporting that the resident, his

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roommate or facility staff were interviewed. After surveyor prompting on 5/12/08, E1 presented another typewritten letter of interviews with R11, R20 (roommate) and facility staff.

According to the typewritten letter dated 5/7/08, "On 5/6/08 at approximately 2:00 AM, resident reported to the CNA that his mattress was on fire. CNA responded by call a code and pulling the fire alarm. A housekeeper was buffing the hall and responded to the room with a fire extinguisher. He stated that the fire was already out because the resident himself smothered the mattress with a sheet. The Fire Department responded immediately and confirmed that the fire was indeed extinguished and the mattress was removed from the facility."

During an interview on 5/13/08 at approximately 12:30 PM, R11 stated, "someone set my bed on fire." R11 stated that while in bed on the early morning of 5/6/08 at "about 2:00 AM," he was awaken and overcome by smoke. R11 stated that he realized that his mattress was on fire. R11 denied that he was responsible for the fire. On review of the Nurse's Note dated 5/6/08 at 2:00 AM, facility staff documented that R11 reported that, "someone started a fire in my room."

R11 reported that someone started a fire in his room by setting his mattress on fire. Facility staff failed to investigate the allegation of abuse. This resulted in the facility's failure to determine the cause of the fire; and/or to determine if the fire was an attempt to cause harm to R11 or any other residents in the facility. The facility failed to investigate an allegation of resident abuse.

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2. R25 is a 61 year old resident with diagnoses including bipolar disorder, asthma and insulin dependent diabetes mellitus. R25 is alert and oriented. According to the most recent resident assessment instrument dated 5/3/08, facility staff identified that R25 had no difficulties with memory recall or cognitive skills for decision making.

During an interview on 5/13/08 at approximately 4:40 PM, R25 stated that during the first or second week of February 2008, she was sexually abused by R24. R25 stated that the resident came to her room and started a conversation with her. She stated that she initially thought he just wanted to talk, but then the resident started to take off his clothing. R25 stated that the resident told her to remove her clothing as well. R25 stated that she was afraid that if she did not do as told, R24 would get angry with her. R25 stated when she removed her clothing, the resident approached her in a sexual way. She stated that she did not scream because she was afraid. R25 stated that she recalls saying, "no, no, no, please...."

R25 stated that R24 forced her to have sex with him. R25 stated that she was afraid to fight him off, for fear of him hurting her. R25 stated that when she informed staff of the inappropriate sexual behavior, she did not use the phrase "he raped me." R25 stated, "that's the only thing I did wrong."

R25 stated that R24 is not allowed on her floor, as she has had a previous allegation of rape against him 6 years ago; and because of his sexually inappropriate behaviors. R25 stated, "he needs help he's sick."

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During the Daily Status Meeting on 5/13/08, facility staff were notified of the resident's allegation of sexual abuse. On 5/14/08 at approximately 3:25 PM, E1 (administrator) approached the surveyor and stated that the director of nursing (E2) was not sure how to handle an allegation of rape. E2 stated that she called the police and would be making a report.

R25 reported that she was forced into having sex with R24. Facility staff were made aware of the sexually inappropriate behavior. However, there was no follow-up. This resulted in the facility's failure to determine if R24's sexually inappropriate behavior was considered rape. The facility failed to investigate an allegation of sexual abuse.

3. R6 was observed on 05/14/08 at 1:00 pm in her room. Surveyor observed R6 did not have any scratches on her face nor both upper extremities. Surveyor also observed E5 (housekeeping) was by R6's room mopping the floor.

Interview with R6 on 05/14/08 at 1:00 pm in her room stated, "I got in altercation with E5. He put his hands on me. He pushed me. We fell on the floor by my room in the hall. He was on top of me. I told him to get off of me. He was applying pressure to my body. It was my upper and lower part. My whole body was hurting. I told the nurse. The security guard (E8) told him to get off of me. He refused. This happen three weeks ago. I'm afraid of E5."

Interview with E5 on 05/14/08 at 1:30 pm in the hall by room 130, E5 stated, "I was in an

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F9999	Continued From page 59 altercation with a female (R6). She walked out of the counselor's office. I was mopping the floor. The resident came and walked on the wet floor. I was playing with her. I told her not to walk on the floor. She was agitated. She began to get upset. She said don't start with me. I tried to redirect her." E5 further stated, "R6 tried to get the broom. She did not get the broom. I pushed her into the room. She came back out of the room. She came back out, reached over my cart and picked up the broom. She came forward to hit me, but didn't hit me. I grabbed the broom and took it. Then I grabbed her wrists. The floor was wet. R6 fell on the floor. I was bending down with my legs across her chest holding her wrists. It was self-defense. I was restraining her." E5 went on to say he was trained in CPI (Crisis Prevention Intervention). Interview with E6 (medical records) on 05/14/08 at 1:40 pm stated, "I was walking through to go to nurses station. E5 was doing his housekeeping job. R6 came past. R6 told him (E5), she was going to get him and was cussing. She took a garbage bag off of the cart and threw it at his head. Then R6 preceded to get the broom and try to hit him. He grabbed her wrists. R6 fell on the floor. Security was called. E5 was bending over R6 while she was on the floor. E5's leg was cross over her chest while she was on the floor." Interview with E7 (certified nurse aide/CNA) on 05/14/08 at 2:00 pm in the north hall stated, "The 3:00pm housekeeper (E5) was mopping the south hall floor. He made a playful statement "R6's don't walk on my floor." He has a strong voice. E5 said why are you walking on my floor? R6 turned around and said, 'Cause I can! Cause I can!' E5 said OK. R6 turned around and said	F9999		

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F9999	Continued From page 60 don't start with me. I don't want your sh--. He (E5) said, R6 go into your room. R6 said I'm not going no where. I left and went to the medication room." According to interview with E8 (Security Guard) on 05/14/08 at 2:40 pm, E8 stated, "I was in the front lobby. I was called to the south side of building with another security guard (E9). E5's legs were across R6's chest. She was lying flat on the floor, face up. E5 had her wrists. R6 was holding E5's pants crotch. When I asked R6 to let him go, R6 said not until he lets me go. She did not want to let him go. I asked E5 to let her go. E5 let her go." Review of the personnel file (dated 11/14/05) for E5 shows, "Z1 (background check) multi hit. Submit fingerprint." During daily status meeting on 05/15/08, E1 (administrator) stated, "We did not submit finger prints on E5." The facility did not present any documentation that they investigated the incident of physical abuse. 4. Review of the nurse's notes for R20 indicates the following: "02/23/08, 5:00pm - Consumer (R20) noted by Director of Social Worker in physical altercation with another resident. 03/15/08 at 8:30 pm - As reported by staff. This consumer (R20) hit another resident in the face. 04/13/08, 6:50 am: Resident hit in the face by another male resident sustaining 0.1 cm scratch to the bridge of his nose. No active bleeding	F9999		

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noted. No redness bruises at this time.

04/14/08, 11:00 am: Resident escorted to nurse station D/T choking and scratching a female PRSC (psychiatric rehab services coordinator) striking her in the face first with his fist. He began clawing at female staff's face where his fingers entered inside of her mouth, scratching inside of her cheek. When other staff came, he began to spit and kick at staff.

05/03/08 - Involved in altercation with peer, states was struck in temple area by peer. Denies any pain at this time.

Review of the assessment dated 02/27/08 shows:

(4). Harm to Self or Other section
(B). Violence - a. Violence to others
1. (any instance prior to last year).
b. Intimidation of others or threatened violence
1. c. Violent Ideation -1.
(C). Any history of sexual violence - 1 (Yes).

5.R15 is a 54 year old resident with diagnoses including Schizophrenia and bipolar disorder.

Review of the nurse's notes dated 11/5/07 shows an entry by a Case Manager indicating that R15 was hit in the face by another resident. R15 ran upstairs stating "I'm going to kill myself." There is no documentation noted that this incident was investigated nor that R15 was monitored for a full 24 hours.

On 11/10/07, the caseworker documented the following:
caseworker came into the nurse's station with

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F9999	Continued From page 62 R15 stated that resident reported to her that she was raped two days ago. R15 was asked to make verbal report to the writer. R15 stated that she had sex everyday with R24 and had problems. Writer asked again if R15 was "raped" or sex. Writer went on to document that she tried to let R15 know the difference between rape and sex. R15 then changed her statement and said she wasn't raped. A voice mail message was left for the responsible party and the physician paged. The ADON was notified. The physician returned the call and ordered a pregnancy test. Review of the February 2008 incident/accident reports did not show that a formal investigation was conducted to determine if R15 was indeed raped. Further review of the incident/accident reports does not indicate that R24 was interviewed regarding this allegation. Review of R24's clinical record shows a history of inappropriate sexual behavior towards women. During interview on 5/15/08 at 11:55am E3 (assistant director of nurses) stated, "I've known this resident for 14 years. R15 is very delusional. R15 has been talking about being 6 months pregnant for years. I don't remember if R15 or a nurse told me about this. But I do know R24. We had a IDT (interdiscipline team) meeting with him and what he's doing is not permissible. R24 said it (sex) is consensual." E3 went on to say that the case worker may have told her, but she would have remembered if a nurse had of informed her about this incident. At 12:20pm E3 returned to the survey team to say that she did remember the case manager	F9999		

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and she is no longer at the facility. E3 also informed the survey team that R15 would have told her about R24 having sex and or raping her.

The facility did not conduct a thorough investigation to determine if R15 was indeed raped.

6. R28 is a 49 year old resident with diagnoses including SAD (schizo-affective disorder) and confidential diagnosis. R28 was admitted to the facility on 2/25/08.

Review of the nurse's notes shows the following:

-on 2/29/08 at 9:00am (late entry for 2/28/08 at 12:45pm), R28 received in dining room sitting up in chair with complaint of being hit in the head by peer with a chair. The nurse assessed R15 and discovered a 1-2cm laceration to the left temple. During the daily status meeting on 5/19/08 the facility was made aware of this incident of resident to resident abuse. The facility did not present evidence that an incident report was done or that a investigation was conducted to determine what happened.

-a late entry dated 3/15/08 at 8:30pm documents as reported by staff member, R28 was hit by another resident. The facility was unable to present any documentation that an incident report was done or that an investigation was conducted.

-On 3/16/08 at 7:30am, R28 was observed on the floor in his room close to the bed. R28 was weak and lethargic with slurred speech. Unable to tell how R28 got to the floor and unable to get up from the floor without staff assistance. R28's

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physician was paged twice. After no response, 911 was called to take R28 to the hospital.

-on 3/21/08 at 5:35am R28 was noted on the floor in his room. R28 was assisted to a wheelchair by staff, assessed and assisted back to bed. There is no indication that the facility initiated a investigation to try to determine why R28 was noted on the floor.
At 10:15am, DSW (direct service worker) reported R28 was noted on bathroom floor. The nurse noted R28 in the bathroom face down, buttocks up. Responsive to verbal and tactile stimulation with slurred speech. R28 sustained a 2.5 x 3 inch abrasion to upper right shoulder. R28 was sent out to the hospital and admitted.

-on 3/25/08 at 5:15pm, R28 was observed on the floor of the activity room. At 5:30pm, R28 reported that he wanted to lay down because he felt tired.

-on 4/9/08am at 7:20am, R28 was escorted to nurse's station by DSW due to noted blood to right eyebrow. Assessment revealed a 0.2cm laceration to the right eyebrow. R28 was unable to tell the nurse what happened.

-4/11/08 at 10:15am R28 was escorted to the nurse's station by activity staff stating R28 was hit with a lock on the back of the head, bleeding noted. R28 sustained a laceration 1 cm in size. R28 was sent to the hospital and required 4 staples to the back of his head.

-4/21/08 at 8am, R28 and a male resident began to fight during the medication dispersement. R28 sustained scratches to the face. On 4/22/08 at 11am, R28 was noted with 3 scratches to the