

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145938	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/04/2010
NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6125 SOUTH KENWOOD CHICAGO, IL 60637		
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{F 406}	Continued From page 18 him a beer and they did not return. R22 got angry and became verbally abusive toward staff and was unable to be redirected. A petition for Involuntary Admission was done due to R22 being verbally and physically aggressive, unable to be redirected by staff as well as suspected alcohol abuse already in progress. As of 4/22/10, R22 remains out of the facility. The most recent care plan dated 2/24/10 does not show a reassessment was done, that new interventions were developed or that the careplan is revised for R21's behavior of drinking alcohol and displaying verbal and aggressive behaviors.	{F 406}			
{F9999}	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.3240d) 300.4050a)4) 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. 300.3240 Abuse and Neglect	{F9999}			

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{F9999}	Continued From page 19 d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the department. (Section 3-610 of the Act) 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S a) The facility shall develop and implement a psychiatric rehabilitation program. 4) Aggression prevention and management, including resident screening (history of aggressive and assaultive behavior, precipitating factors, signals of escalating risk, and effective de-escalation strategies); identification and modification of environment risk factors (e.g., physical plant and resident mix); provision of skills training, behavioral, and appropriate psychopharmacological interventions based on individualized resident assessment; and policies and procedure for rapid response to behavioral emergencies. These requirements are not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 4 residents (R19, R20, R21, R22) in the sample who have a history of behavior problems. The facility failed to develop a comprehensive treatment plan with interventions for dealing with physical and verbal aggression for these 4 residents. The facility failed to keep one resident in the sample (R19) safe from resident to resident (R20 and R21) physical abuse and aggression. The facility failed to	{F9999}			

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{F9999}	<p>Continued From page 20</p> <p>monitor and supervise to diffuse and prevent physically aggressive behavior. These failures resulted in numerous physical and verbal altercations from 2 residents in the sample (R20 and R21). This lack of supervision and monitoring resulted in R20 and R21 harming R19 with a 40 ounce beer bottle on 04/17/10 on the outside pavilion. The facility failed to notify the state agency regarding the resident to resident abuse.</p> <p>Findings include:</p> <p>1. R19 is a 35 year old female with diagnoses including Paraplegia, Convulsion, Depression, Idiopathic Scoliosis, Previous Spinal Surgery, and Status Post Left Vagus Nerve Pacer Implantation. R19 is alert and oriented to person, place and time.</p> <p>R19 was observed on 04/19/10 at 10:00am in a motorized wheelchair sitting at the nurse's station. R19 also was observed with an indwelling catheter.</p> <p>The nurse's notes dated 04/17/10 denoted resident (R19) reporting that two residents (R20 and R21) from facility physically attacked her. During the attack R19 was hit on the right side of her face and shoulder with a 40oz (ounce) beer bottle. Upon assessment, slight swelling and redness noted on right side of face. Resident alert and oriented X 3. Complaint (of) pain on right side of face. Rated pain 6 on scale 1- 10.</p> <p>The incident report dated 04/17/10 at 4:30 pm indicates received resident complaints that two residents from facility began to fight her, one resident picked up an 40 oz beer bottle hit her on</p>	{F9999}			

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{F9999}	<p>Continued From page 21</p> <p>the right side of her face, fight broken up by six facility staff members. Upon assessment slight swelling and redness noticed on right side of face.</p> <p>The police report dated 04/17/10 at 1630 documents offense/incident - primary classification was "Battery."</p> <p>On 04/19/10 at 4:10 pm two Surveyors observed the outside pavilion which is located next to the facility. The 2 Surveyors observed 3 male residents sitting and smoking cigarettes. Surveyors did not observe any staff monitoring the Pavilion during this observation.</p> <p>On 04/21/10 at 1:30 pm in the conference room, E3 (Social Service Management) stated, "(R19) is in a motorized wheelchair. She is paralyzed from the waist down. It was reported to me they were out in the pavilion and she got into a verbal altercation with another resident. The verbal altercation went into physical altercation. She was hit by a resident (R20) on the head with a large beer bottle outside. Yes, the pavilion is part of the facility property. R20's boyfriend (R21) also was involved in the verbal and physical altercation with R19. As it was reported, R21 got into it with R22. R22 observed the fight and got up to help protect R19. R22 swung his cane to hit the other residents (R20 and R21). No, there was no staff monitoring and supervising the pavilion.</p> <p>On 04/22/10 at 1:30 pm in the conference room R19 stated, "I don't want to talk about it. They were drunk. She hit me with the bottle. They were both drunk. R21 was drunk and not able to stand. They drink out there in the pavilion. They</p>	{F9999}			

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{F9999}	<p>Continued From page 22</p> <p>(residents) drink alcohol, smoke marijuana and crack. There was no staff out there to monitor residents. It all started because I said 'Hi' to R20's boyfriend (R21). I didn't know she (R20) and R21 were drunk. She (R20) hit me with an open hand. She had the bottle in the other hand. She (R20) threw it at me. It was 2/3 full with beer. It fell to the ground. My face was swollen and red. I had pain on the side of my face where I was hit."</p> <p>2. R20 is a 41 year old female with diagnoses including Seizure disorder, Parkinson disease, Convulsions. Episodic, Mood Disorder, Depression Disorder and Agitation.</p> <p>The nurse's notes indicate the following:</p> <p>-On 04/12/10 at 5:00 pm - Resident (R20) came up to the floor from the elevator. Resident stated that she had a physical altercation with another resident outside in the pavilion due to them owing her \$1.00 for a cigarette. Resident further stated that she slapped the resident because he refused to give her the money. Resident was spoken to by this writer regarding alternative ways that could have been approached before leading to the physical altercation that occurred. This writer further stated that the resident needs to express her feeling in a positive manner rather than resorting physical aggression.</p> <p>-04/17/10 at 4:00 pm - This writer received report that resident (R20) was at the pavilion and had an physical altercation with peer. It was stated that resident and her boyfriend (R21) was hitting peer with beer bottles. Resident stated that peer told her to sit down on a bench and she doesn't</p>	{F9999}			

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{F9999}	<p>Continued From page 23</p> <p>like to be told what to do. Resident stated peer (R19) raised her voice and swung her hand and that's when resident (R20) and boyfriend (R21) began to hit peer (R19). During altercation resident (R20) was struck by peer (R22) with cane in right forearm. This writer observed resident (R20) had some swelling to her right distal forearm area was red and sensitive to touch. Resident complained of pain and discomfort. Resident sent out to the hospital.</p> <p>The petition report dated 04/17/10 indicates resident (R20) was verbally and physically aggressive toward peers. Unable to be redirected. Resident struck another peer in the head with a glass bottle. Resident is non-compliant with staff and aggressive toward staff.</p> <p>On 04/20/10 at 3:15 pm in the conference room E5 (nurse) stated, "It happened on the pavilion. There was an altercation between two of my residents and another resident. There are supposed to be Psych technicians in the pavilion."</p> <p>At 3:10 pm in the conference room, E4 (Nurse) stated, "I was passing medication. (R19) came on the floor. She notified been altercation. She told me want to call police. They jumped on me. I was sitting outside and 2 other residents jumped on me. They attacked me. One hit me in the face with a beer bottle. But a couple minutes later she slapped my face (R19) had minimum face pain. The police was notified. (R19) does not have any problem with alcohol or substance abuse."</p> <p>On 04/20/10 at 3:30 pm in the conference, room E6 (nurse) stated, "I was on the 6th floor and a</p>	{F9999}			

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{F9999}	<p>Continued From page 24</p> <p>code was called. It was for the pavilion. As I got there, (R19) said (R21) hit her in head with a beer bottle. (R19) states she (R20) slapped me."</p> <p>On 04/21/10 at 3:40 pm, E7 (Psych Technician) stated, "I was upstairs on the 6th floor when this happened. I responded to the code when they said all Psych Techs to the pavilion. When I got there, there was an argument between (R19, R20 and R21). There was a broken beer bottle on the ground in the pavilion. It was a big beer bottle. It was on the side of the chair in the pavilion. The Pavilion is part of the facility property."</p> <p>On 04/22/10 at 12:20 pm in the conference room, E14 (Psych Technician) stated, "I was assigned to the chapel. I make rounds to the pavilion every hour. I was on lunch. As I was walking to my car I saw them in the pavilion fighting. I ran over, (R20) was fighting another resident (R19). I stopped the fighting. (R19) was in a motorized wheelchair. (R20) and I was walking off. I heard (R19) say (R20) threw a bottle at me. He (R21) was fighting (R19). He (R21) was actively trying to stop (R19 and R20) from fighting. I saw (R19 and R20) was fighting."</p> <p>3. R21 is a 57 year old resident who has diagnoses including bipolar disorder, seizure disorder, an CVA (cerebral vascular accident). R21 has a history of alcohol abuse and noted being intoxicated while inside the facility as well as in the community. R21 also has a history of numerous physical and verbal altercations with other residents as well as being verbally abusive toward staff. R21 has orders to receive Phenytoin (anti seizure medication) 100mg, 2 capsules by mouth twice daily (9am and 5pm).</p>	{F9999}			

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{F9999}	<p>Continued From page 25</p> <p>Review of the Aggressive Behavior Incident Investigation sheet dated 4/17/10 (4:00pm) documents R21 and R20 attacked R19 who is wheelchair bound while out on the pavilion. R21 was angry because he gave another resident money to purchase beer. That particular resident did not return with R21's beer.</p> <p>On 4/20/10 at am, E3 (social services) was asked if staff are required to supervise the pavilion. E3 said yes and that the psych techs are to make rounds every hour. But for this incident, there was no staff in the pavilion.</p> <p>R21 was sent out as an Involuntary Admission to the hospital due to paranoid ideations and resistant to redirection from staff. On 4/18/10 At 2:00am, R21 was admitted to a community hospital's psychiatric hospital unit, diagnosis unknown due to alcohol.</p> <p>The most recent care plan dated 2/24/10 does not show a reassessment was done, that new interventions were developed, or that the care plan is revised for R21's behavior of drinking alcohol and displaying verbal and aggressive behaviors.</p> <p>4. R22 is a 56 year old resident with diagnoses including schizo-affective disorder. R22 was admitted to the facility on 3/11/10. R22 does not have a history of physical or verbal aggression toward other residents or staff.</p> <p>Review of the (Multi-Purpose) Incident Report dated 4/17/10 (4:00pm) documents R22 told nursing staff he witnessed R20 and her boyfriend (R21) attack and hit R19 with beer bottles while out in the pavilion. R22 said he hit R20 with his</p>	{F9999}			

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{F9999}	<p>Continued From page 26</p> <p>cane trying to help R19 fight them off. R22 hit R20 with his cane on her arm. R22 also told staff he had sent someone to buy him a beer and they did not return. R22 got angry and became verbally abusive toward staff and was unable to be redirected.</p> <p>A petition for Involuntary Admission was done due to R22 being verbally and physically aggressive, unable to be redirected by staff as well as suspected alcohol abuse already in progress. As of 4/22/10, R22 remains out of the facility.</p> <p>The most recent care plan dated 2/24/10 does not show a reassessment was done, that new interventions were developed or that the care plan is revised for R21's behavior of drinking alcohol and displaying verbal and aggressive behaviors.</p> <p>R20, R21 and R22 were all sent out to the hospital for psych evals due to their escalating behavior and not being able to be redirected by staff.</p> <p>The facility did not present any documentation to support that the residents are monitored or supervised while in the pavilion. The facility did not present any documentation that this incident was reported to the state agency.</p> <p style="text-align: center;">(A)</p>	{F9999}			