STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E205	A. BUILDING _____ B. WING _____	11/29/2010

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F 490	Continued From page 42 This will be completed on November 22,2010. 8. All action implemented above will be reviewed monthly by the facility's Quality Assurance Committee for the net 3 months to ensure the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		
F9999	- FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.625g)1)2) 300.625i) 300.625j) 300.625k) 300.695b)2) 300.695c)	F9999		

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F9999	Continued From page 43 300.1210a) 300.3240a) 300.3240f) 300.4010a) 300.4010b) 300.4010c)3)E) 300.4030a)1) 300.4030h) 300.4040c)5) 300.4050a)1)D)4) 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 300.625 Identified Offenders g) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements: 1) The facility shall inform the appropriate county and local law enforcement offices of the identity of identified offenders who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense who are residents of the facility. If	F9999		

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F9999	Continued From page 44 a resident of a licensed facility is an identified offender, any federal, State, or local law enforcement officer or county probation officer shall be permitted reasonable access to the individual resident to verify compliance with the requirements of the Sex Offender Registration Act, to verify compliance with the requirements of Public Act 94-163 and Public Act 94-752, or to verify compliance with applicable terms of probation, parole, or mandatory supervised release. (Section 2-110(a-5) of the Act) Reasonable access under this provision shall not interfere with the identified offender's medical or psychiatric care. 2) The facility staff shall meet with local law enforcement officials to discuss the need for and to develop, if needed, policies and procedures to address the presence of facility residents who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense, including compliance with Section 300.695 of this Part. i) Facilities must annually complete all of the steps required in subsection (g) of this Section for identified offenders. This requirement does not apply to residents who have not been discharged from the facility during the previous 12 months. j) For current residents who are identified offenders, the facility shall review the security measures listed in the Criminal History Analysis Report provided by the Department. k) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in	F9999		

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F9999	Continued From page 45 an individualized plan of care. Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident; 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure; 4) Seeking advice concerning preservation of a potential crime scene; 5) Facility investigation of the situation. Section 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 psychological 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	F9999		

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F9999	Continued From page 46 personal care needs of the resident. 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) 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) Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her	F9999		

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F9999	Continued From page 47 guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs. b) The IDT must identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC. c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior tadmission. The assessment shall include at least the following: 3) A skills assessment performed by a social worker, occupational therapist, or PRSD or PRSC with training in skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning, including but not limited to the following areas: E) Symptom management skills (including symptom monitoring and coping strategies; stress identification and management; impulse control; medication management and self-medication capability; relapse prevention); and Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S	F9999		

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F9999	Continued From page 48 a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others); h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan. Section 300.4040 General Requirements for Facilities Subject to Subpart S c) The facility's psychiatric rehabilitation program shall have the following overall goals: 5) Decrease psychotic, self-injurious, antisocial, and aggressive behaviors;	F9999		

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F9999	Continued From page 49 Section 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S a) The facility shall develop and implement a psychiatric rehabilitation program. A facility may contract with an outside entity to provide all or part of the psychiatric rehabilitation program as long as individual residents' needs are met and subsection (c)(4) is met. The program shall be designed to allow a wide array of group and individual therapeutic activities, including, but not limited to, the following: 1) Skills training programs addressing a comprehensive range of skill areas, including the major domains of self-maintenance, social functioning, community living, occupational preparedness, symptom management, and substance abuse management. Skills training programs should: D) Be adjusted in content, form and duration to match residents' profiles in terms of stress tolerance, learning impairments, and motivational characteristics. Environmental conditions shall be arranged to help compensate for deficits in resident concentration, attention, and memory (e.g., reduction of distracting stimuli and extensive use of supportive reminder cues), as needed. 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	F9999		

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F9999	Continued From page 50 and procedure for rapid response to behavioral emergencies. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to conduct a risk assessment, which included a social evaluation prepared by the Department of Corrections for one (R28) of two Identified Offenders in the sample. On 8/14/2010, at approximately 3:30am, R28 physically assaulted R4 sending the resident to the hospital with 3 fractured ribs, a fractured vertebrae and collapsed lung. The facility failed to develop a comprehensive plan of care appropriate to all needs of the identified offender, including triggers that would precipitate violent behavior. The facility failed to assess R28's propensity toward violent behavior and R4's potential for becoming a victim of violence per facility's Abuse Prohibition program The facility failed to perform a rigorous, comprehensive assessment in order to develop a program to address identified behaviors. The facility failed to ensure that R28, who were identified as having Severe Mental Illness, received adequate mental health rehabilitative services to address his aggressive behaviors. In addition, the facility failed to provide adequate supervision for R28 who had a history of aggressive behavior and medication noncompliance. In addition, the facility failed to have a policy on calling local law enforcement when a resident is found injured or dead. On 8/14/10, at approximately 7:00am, R4 was found by E7 (3rd	F9999		

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F9999	Continued From page 51 floor Charge Nurse), holding his side in pain at approximately 7:00am on 8/14/10. Law enforcement was not contacted until R4's family called them from the hospital. In addition, the facility failed to develop policies and procedures or failed to assure facility staff were following the policies already in place, as follows: 1. No policy related to increased monitoring for residents when resident's escalating behaviors indicate it is warranted. 2. No policy for residents with history of cheeking/non compliance with taking medication. 3. No policy related to contrabands brought into facility by residents as well as a search policy that includes a comprehensive time frame for conducting searches (including room search) for residents who are suspect for bringing contrabands into the facility including residents who made threats of bringing contrabands into the facility. 4. Failed to insure an injury of unknown origin was investigated by staff per abuse policy. Findings Include: 1. R28 is a 27 year old male with a diagnosis of Schizoaffective D/O Bipolar Type that was admitted to the facility, 11/12/09. His criminal background check indicated a conviction for Burglary. The resident was in the custody of the Department of Corrections in the year 2006. No risk assessment with a social evaluation from the Department Corrections was found in the resident's paper work. 2. A 3/26/10 note in R28's clinical record under his social service notes (written by E4 PRSC)	F9999		

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F9999	Continued From page 52 indicates that the resident's imprisonment was increased from 3 years to 6 years for physical altercations while incarcerated. R28 told his PRSC (E4) he received an additional 3 years to his burglary sentence for being involved in a "few physical altercations" while incarcerated. The resident, also stated that certain key people in his life was against him such as his parole officer, and added that he was the "victor" in the altercations. E4 further states in his note: "It is difficult to locate the line in his personal history between factorial events and delusional thought content." E4 in a note dated, 4/7/10 stated that R28 had "2 bad episodes" during a home visit at his mother's. The facility had not sent the resident home with all of his medication (Valproic acid) and R28 started hitting walls. E4 was interviewed 9/1/10, on the first floor concerning this note. After going over the 3/26/10 note's content and the note dated 4/7/10 about R28's home visit with his mother, E4 was asked if any new assessments of R28' behaviors were done. E4 did not answer the question or give any other further response. 3. On 8/31/10, at approximately 2:00pm, E1 (Administrator) and E6 (Clinical Director) were interviewed in the first floor conference room, concerning R28's missing risk assessment. E1 stated that R28's name was submitted to the State for assessment. "They never did it." E1 and E6 were asked if the facility went ahead and assessed. They said, "No." 4. On 8/14/10, at approximately 7:00am, R4 was found by E7 (3rd floor Charge Nurse),	F9999		

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F9999	Continued From page 53 holding his side in pain. R4 was sent out to the hospital, where he was diagnosed with 3 fractured ribs, 4 fractured vertebrae and 1 collapsed lung. On 8/31/10, at approximately 2:45pm, E7 was interviewed by telephone concerning the incident dated 8/14/2010 that involved R4. "I found R4, badly bruised and holding his side the morning of 8/14/10. I asked R4, what happened? He would not tell me. I immediately called, E2 (DON) to send him to the hospital. I did not call the police." 5. On 9/1/10, at approximately 2:55pm, E9 (Q.A. Coordinator) was interviewed in the first floor conference room. E9 is the identified staff member responsible for performing abuse investigations. The 8/14/10 incident was discussed with E9. "No abuse investigation was started until we found out that R4 was hit by R28. The first people the resident told he was hit by another resident were the Emergency Medical Technicians (EMT's) drivers. So we had no reason to start an abuse investigation at 7:00am when he was found." At 7:00am, 8/14/10, R4 had an injury of unknown origin. The facility staff did not call the police or promptly initiate an investigation. On 9/16/10, in the first floor conference room, E1 (Administrator) and E9 were both asked whether the facility had a policy on when the staff is to call the police. They both said the facility had none. 6. On 9/16/2010, Z1 (Sister of R4) was interview by telephone. Z1 stated that the family was called and told that their brother was in the hospital. "My brother told me and the hospital emergency staff that his roommate beat him. Hospital personal	F9999		

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F9999	Continued From page 54 said we should call the police. We did. Police investigated and wanted my brother to sign a police report for aggravated battery against R28, after they had gone to the facility and found out that facility had confiscated an iron, exacto knife and shaving razor out of room 502. My brother refused to sign the report because he was afraid of what R28 would do to him." Police report #10-022468 was obtained from Z1. 7. On 8/31/2010, at approximately 1:30pm, R4 was interviewed in his room (502) concerning the incident dated 8/14/2010, in which he was assaulted by R28. "He (R28) beat me with his fists of steel. He threw me across the room into the bathroom. I was unconscious. After I woke up, I went back to bed. I didn't tell anyone because I was afraid that he would hit me, again." 8. R11, another roommate of R4 was present at the time of the interview with R4. R11 was asleep in the room at the time of the assault. R11 stated, "I didn't hear anything. I had taken my 10:00pm medication and slept right through it. But, I will say this about R28. R28 was a 'time bomb' waiting to explode. He would walk around the room hitting the (privacy) curtains with his fist. He hit the closet and bathroom doors with his fist." A rectangular hole (shape of a fist) was observed in the closet door. The hole in the bathroom door was squared. On 9/1/10, during the Daily Status meeting, E1 (Administrator) explained away the bathroom door hole as being made by a door knob. Because of the shape of the closet hole, it could not be explained away. The hole in the closest	F9999		

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F9999	Continued From page 55 door was one and half times larger than the fist of the surveyor. 9. On 8/31/2010, at approximately 4:10pm, E5 (CNA) was interviewed by telephone. E5 worked the 11pm to 7am shift of the 5th floor, the night of the incident. "We make rounds every 30 minutes. I saw R4 and R28 at 3:30am. R4 was in his bed. He was not moving, but I went up to him and called out his name. He moaned. Normally, R4 is awake. R28 was standing by his bed. I made sure where he was because the '24 hour report' said that he had not taken his 10:00pm meds." R28's medication administration report showed a refusal. It was blank on the other side. 10. On 8/31/2010, at approximately 2:45pm, E2 (LPN) was interviewed by telephone. E2 stated, "The CNA came and got me to look at R4. The CNA saw bruises on his elbow. I did a body search. He refused to talk to me. He was holding his ribs. I called the DON and his Doctor to send him out." R4 was sent to the hospital where he was diagnosed with 3 fractured ribs, 4 fractured vertebrae and 1 collapsed lung. 11. The facility's "Abuse Prevention Program Facility Procedures" under Article III, reads. "Resident Assessment. As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis.	F9999		

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F9999	Continued From page 56	F9999		

Pattern Assessment. At least quarterly, the Quality Management committee will review concern identification reports, accident reports, incident reports, missing items reports and safety committee reports to assess possible patterns or trends of suspicious bruising of residents unexplained accidents, or other occurrences that may constitute abuse, neglect or theft. Based on assessment of the reports, the Quality Management committee will further investigate and/or determine whether a change in facility practices is warranted."

12. On 9/1/10, E1 (Administrator) and E8 (Corporate) were interviewed and asked if an abuse assessment was done on R4 or R28 before the 8/14/10 incident. E8 stated that facility does not do "formal' abuse assessment sheet for residents. R4 and R28's clinical records were reviewed, and no abuse assessment was found.

13. In a social service progress note, dated 3/26/10, written by E4 (R28's PRSC), R28 describes his stay in prison and what got extra years added to his sentence.

"R28 also described getting into a few altercations while incarcerated. He was the victor in all exchanges and, although he had no choice but to defend himself, these altercations caused him to serve a longer sentence. It is difficult to locate the line in his personal hx (history) between factual events and delusional thought content."

E4 in a note, dated 4/7/10, stated that R28 had "2 bad episodes" during a home visit at his mother's. The facility had not sent the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E205	A. BUILDING _____ B. WING _____	11/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY CARE	901 MAPLE AVENUE EVANSTON, IL 60202

(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
F9999	Continued From page 57 home with all of his medications (Valporic acid) and R28 started hitting walls. Another note dated 7/24/10, states that a sweep of the resident's room had to be done because R28 threatened to bring weapons into the facility. A quarterly care plan note, dated 5/18/10, written by E4, talks about R28's verbal aggression and medication "cheeking" (not taking medication). A "Follow-up Report of Occurrence," dated 6/28/10, states R28 had bruised knuckles and skin tear on his right hand. The only person questioned about the incident was the resident. No other evidence was presented as to how he bruised his knuckles. On 8/30/10 and 8/31/10, during a series of interviews with E1 (Administrator), E6 (Clinical Director) and E9 (Abuse & Q. A. Co-coordinator), the above progress notes and incidents previous to the 8/14/10 incident were discussed. E1 stated that R28 said his mother was drug addicted and made everything up. The facility did not present any evidence that a thorough investigation was ever done of the bits and pieces of suspicious information that was being accumulated on R28. For example, E1 never said that R28's mother was contacted and told of her son's allegations of drug abuse. Regarding the skin tear and bruised knuckles (6/18/10), only R28 was consulted. The incident report never stated that any staff member examined the location of the incident. Quarterly assessments did not show that any of the above incidents were discussed or assessed. E9 stated that R28 "never did anything in the facility to warrant more supervision." On 7/24/10,	F9999		

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F9999	Continued From page 58 the resident stated that he would bring weapons into the facility. Police report, dated 8/14/10 1442 hours, stated E9 found a shaving razor, exacto knife and iron in R28's room which she turned over to the police. 14. Per record review, R28 had a problem with being medication compliant. R28 was care planned for "cheeking" his medication. Further interview and record review, showed that the facility had no system in place for monitoring R28's medication compliance. R28's medication compliance was discussed in a Social service note written by E4. It states that the resident "had clinical issues of anxiety and paranoia" resulting in problems with "verbal aggression and medication cheeking. Res' still struggles with med compliance." R28 has a care plan for "cheeking" medication. On 11/17/2010, during the Daily Status meeting, facility staff were asked for some procedure on how they monitor resident's "cheeking" medication. No written procedure was given. 15. Facility staff had recorded several incidents involving R28 that were not thoroughly investigated. The incidents showed hints of R28's aggressive behavior. When discussed with staff members at Daily Status meetings, it was noted that R28 was allowed to explain away whatever happened. No further investigation was done. The facility did not step up their monitoring of R28. 16. On 7/24/10, a Social service note states. R28's room had to be searched for weapons. The resident had talked about bringing in weapons. During a Daily Status meeting, staff stated that	F9999		