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	14E147	A. BUILDING _____ B. WING _____	04/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBUS MANOR RES CARE HOME	5107 21 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(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 514 SS=D	Continued From page 89 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation and interview facility failed to have current medication administration record for 1 of 14 residents (R14) in a sample of 24, and failed to follow generally accepted professional standards related to accurate documentation involving 2 of 24 sampled residents (R2,R6) Findings include: During the survey on 4-7-11 thru 4-8-11 observed no April 2011 medical administration record for R14 in the nurse ' s station medication book. Interview with E3 (Director of Nursing) at 9:45 AM on 4-8-11 states the medication administration record has been misplaced and we have not been able to locate it since yesterday. Review of the MAR(Medication Administration Record) dated January of 2011 of R 2 indicates	F 514		

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F 514	Continued From page 90 that resident receives 1 can of 2-Cal nutritional supplement daily. The MAR has blood pressures located where the nurses signatures should be. The MAR also indicates weekly weights. The MAR has pulse rates located where the nurses signatures should be. Review of R 6 record indicates that an order for Ambien 10 milligrams every hours sleep as needed was ordered on 10-20-10. Noted in the record was the consent signed by R 6 but dated 3-3-11. On 4-7-11 at 4:30pm during the daily status meeting, the facility was notified of the concerns.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)6) 300.1220b)3) 300.2900d)2) 300.3100d)2) 300.3240a) 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	F9999		

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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

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 personal care needs of the resident.

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's

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orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.2900 General Building Requirements
Section 300.3100 General Building Requirements

d)2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

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

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F9999	Continued From page 93 of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Requirements were not met as evidenced by: Based on interview and record review the facility failed to monitor, provide supervison and prevent the elopement of 1 sampled resident from a sample of 24 (R23). R23 was identified as being unable to access the community without supervision, and R23 is also an identified offender assessed to be moderate risk requiring supervision and frequent monitoring. This failure resulted in R23 eloping from the facility, and being involved in a motor vehicle accident, sustaining a fracture to the right lower extremity. The facility also failed to prevent two additional residents (R10, R16) from leaving the facility unsupervised. R10 is a registered child sex offender who is not supposed to leave the facility unsupervised. R16 was on a Level One Pass Privilege meaning that he was not to leave the facility without family or staff supervision. Findings include: 1) R23's criminal history analysis report dated 3/15/10 indicates that R23 is an identified offender with a history of sexual aggression. R23 was assessed to be moderate risk indicating R23 requires closer supervision and more frequent observations than standard or routine. A review of R23's current care plan dated 12/7/10 showed there was no care plan developed to supervise or frequently monitor R23. No plan of	F9999		

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care integrated R23's assessment of being at moderate risk which required close supervision and frequent monitoring.

R23's clinical record - community survival skills assessment dated 2/18/11 indicates in the note that R23 continues to be at pass level 1 (restriction) due to leaving the facility unauthorized on 2/17/11. The note indicates that R23 returned to the facility late around 9:00pm. Yet, the following page indicates that R23 is not an elopement risk, and has no history of elopement.

According to the facility incident report dated 2/21/11 at 6:55pm, R23 left the facility and was struck by a car. The report indicates that the facility was notified of the incident from the admitting hospital. R23 was taken to the hospital emergency room by the local police department. The report indicates that R23 was admitted to the hospital with a fracture of the knee.

On 4/15/11 at 1:30pm, E5 (social service director) said that R23 left the facility unauthorized on 2/17/11. E5 said if a resident leaves unauthorized it is considered an elopement. E5 said when a resident displays this behavior the psycho-social caseworker should develop a plan of care with interventions to deter/prevent the resident from future incidents of elopement. E5 said that R23 should have been re-assessed to be at risk for elopement.

According to R23's current plan of care dated 12/7/10 no care plan was developed after R23 elopement from the facility on 2/17/11.

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R23's nursing note dated 2/21/11 8:00pm indicates that at 5:30pm R23 left the facility. At 6:55pm, the hospital called notifying the facility that R23 was at the hospital and R23 was involved in a motor vehicle accident. The note indicates R23 sustained minor injuries and will not be admitted. Nursing note dated 2/22/11 6:00am indicates that R23 will be admitted to the hospital with a diagnosis of right knee fracture.

The social service note dated 2/22/11 indicates that R23 was admitted to the hospital last night, after being hit by a car. The note indicates that nursing staff was informed that R23 was brought to the hospital by the local police department.

On 4/15/11 at 1:00pm, E3 (Director of Nursing) said that she was notified at home the evening of 2/21/11 by facility nursing staff that R23 had eloped from the facility, was involved in a motor vehicle accident and sustained a fracture to the right lower extremity.

According to the facility's sign in/sign out log for 2/17/11 and 2/21/11, R23 had not signed out of the facility.

On 4/15/11 at 3:30pm, E24 (receptionist/security) said that she worked the front desk on the evening of both 2/17/11 and 2/21/11. E24 said that she does not recall R23 leaving the facility and does not recall R23 signing out of the facility during her shift.

Observation of the facility front door noted there were (2) sets of double doors, the inside double door on the left hand side was controlled electronically and the right sided door opened

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when pushed. The door on the right side did not lock and was observed throughout the course of the survey not to lock from the inside. On 4/15/11 at 3:45pm, E9 (administrator) said that the right side door would not lock because it would be a fire hazard, E9 said that she had documentation from OSHA. E9 was unable to provide survey team with OSHA documentation.

The facility's elopement policy states the facility shall identify potential safety hazards as part of its quality assurance program and address these issues as warranted. The policy also states an assessment addressing the individual's potential for elopement or unauthorized departure shall be performed in accordance with the facility's documented policy. Residents identified as being at risk shall have care plans in place describing prevention strategies which may include behavior strategies and supervision. Residents identified as being at risk should only leave the facility when accompanied by a responsible individual.

According to the facility's 24 hour front desk security policy and procedure, under no circumstance is the front desk to be left unattended at any time. Keep front door locked at all times residents are to be buzzed in. The policy also indicates that the front desk security person will monitor all residents sign in/sign out and checking all residents' pass privilege level prior to allowing residents to sign out. Every resident must sign in and out every time they leave the facility. The policy also denotes residents identified as being at risk should only leave the facility when accompanied by a responsible individual. The policy states if any

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F9999	Continued From page 97 resident is observed eloping from the facility, front desk personnel on duty are to immediately announce Code Yellow, via the intercom system. 2) R10 was admitted to the facility on 7/14/10 with diagnosis of Bipolar Disorder and Depression. Per Illinois State police Criminal Background Check initiated on 7/16/10, R10 is an identified offender and a registered child sex offender. Review of the criminal history data for R10 indicated that he is registered as a child sex offender and was also imprisoned for attempted rape and burglary. The Illinois Sex Offender Online Search verified that police report and further indicated that he was convicted as a child sex offender, convicted for rape and aggravated sexual abuse of a victim <13 years old. Review of R10's nurses notes indicated that he was also involved in the following aggressive behaviors and altercations with other residents in the facility: a) 10/12/10 at 10:30 AM, R10 reported that another resident hit him and he sustained a black eye. b) 10/28/10 6:30 PM, hit another resident, was verbally aggressive to staff. c) 11/23/10 at 10:00 AM - yelling and screaming at staff and threw chairs.	F9999		

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F9999	Continued From page 98 d) 12/20/10 at 10:30 AM - hit another resident stating he did so because the other resident laughed at him and killed his 2 friends. e) 1/31/11 at 2:00 PM - agitated at staff and other residents. f) 3/12/11 at 5:40 PM - was hit on one side of the face and was bleeding. Furthermore, R10 is also not safe unsupervised as he had histories of falls per nurses notes on 11/29/10, 12/9/10, and 2/10/11. On 11/29/10 at 5:00 PM, R10 slipped off a chair and fell on his side. On 12/9/10 at 6:00 AM, he was found laying on the floor with a hematoma on his forehead per nurses notes. On 2/10/11, R10's nurses notes indicated he also fell while on his outside program. There was no indication in his care plan and record that the facility put in place interventions to prevent him from falling further, nor was there evidence that an assessment to determine cause of falls was done. E4 (Asst. Director of Nursing) verified during interview of 4/7/11at 1:40 PM that R10's care plan was not showing any intervention each time R10 fell. E4 also was not able to show evidence that there was an assessment for each fall done to determine causes so appropriate intervention can be put in place. R10's nurses notes dated 3/4/11 indicated that at 2:00 PM, R10 stated that he was leaving the facility after putting his personal belongings inside a garbage bag. This nurses notes indicated that this resident was told he was back home and that the facility is not the hospital that R10 thought discharged him already.	F9999		

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F9999	Continued From page 99 When E3 (Director of Nursing) was interviewed on 4/7/11 at 2:25 PM, E3 said that on 3/4/11 R10 went to the nurse's station after lunch time, and verbalized that he wanted to leave the facility. E3 said that she called the front desk security and told security to watch out for R10. E3 said that later they could not find him and no staff saw him leave. When E21 (security) was interviewed on 4/7/11 at 1:50 PM, E21 said on 3/4/11 just after he came back from his break, E3 asked him if he had seen R10 because R10 could not be located in the building. E21 said he later overheard that R10 got out of the building and took a bus. E21 said he did not see R10 leave the door and if R10 left through the exit door, it would have triggered a light on the front desk that the exit door was opened, but it did not. Per above 4/7/11 interview at 2:25 PM, E3 confirmed that no staff saw R3 leave the building. E3 said that one resident saw R10 get to the bus. Per observation on 4/8/11 at 12:10 AM, the front door will not open unless the switch on the wall by the front desk is flipped. Per observation, there is a high school at the corner across from the facility, less than 500 feet away from the front door of the facility. Per Community Survival Skills Assessment dated 2/19/11, R10 is not capable of unsupervised outside pass privileges due to continued delusional and disorganized thought processes.	F9999		

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On 4/8/11, the facility finally found out where R10 was when a hospital called that R10 wanted to come back to the facility.

3) R16 was admitted to the facility on 8/31/10 with diagnosis of Paranoid Schizophrenia.

Per nurses notes, R16 eloped from the facility on the following dates:

a) 10/27/10 - eloped from facility

b) 11/8/10 8:50 AM - eloped from the facility by walking out of the door. Staff went outside to look for him but R16 was long gone by then. R16 returned to facility at 8:30 PM.

c) 11/9/10 3:45 AM - eloped by pushing the front door open and continued to just walk away from the building. At 7:45 AM, R16's sister said that R16 is not with her. At 8:55 AM, brought back to the facility handcuffed by the police and sent to the hospital.

d) 11/26/10 went outside of the facility without shoes, socks, or coat. Staff chased him back and he was sent to the hospital. 11/26/10 hospital History and Physical indicated that at the facility, R16 was confused, delusional and ran out of the facility in freezing cold weather without coat and shoes.

e) 12/12/10 2:30 AM - pushed open the front door and left. Per nurses notes dated 12/12/10, R16 told the guard he was leaving but he will be back. The guard went out of the door to look for him but he was gone already. No indication why the guard allowed him to leave in the first place. Returned at 8:30 AM on 12/12/10.

f) 12/19/10 5:00 PM - witnessed by staff as had left without signing out. Returned at 2:10 AM

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the next day. Per incident report of the same date, R16 ran out of the facility.

g) 12/29/10 5:00 PM - cannot be located in the building. returned on 12/30/10.

h) 1/1/11 2:15 AM - Observed by security putting a chair up to the fence and climbing over fence. Staff called him but he ignored staff and left.

i) 2/26/11 9:15 AM - walked out of the facility and returned at 2:30 PM.

R16's Social Service Quarterly Report dated 10/24/10 also indicated that he had one episode of attempting to jump over the fence on 8/25/10.

Review of R16's Social Service Quarterly note dated 1/24/11 showed that R16 has a pass privilege of Level One. During daily status on 4/7/11, E5 (Social Service Director) said that a Level One Pass Privilege means the residents cannot leave the facility without staff or family supervision outside.

According to R16's Community survival Skills Assessments dated 11/19/11 and 2/19/11, R16 is not capable of unsupervised pass privileges at the time of assessment.

R16's Community Survival Skills Assessment dated 2/19/11 indicated R16 follows rules addressing participation in his treatment plan, has the ability to adhere to pass privilege policies, and has knowledge of potentially dangerous situations. These were all coded as YES in the assessment even though R16 does not follow nor even attend his treatment plans, does not adhere to pass privilege policy as shown above in the elopement examples, and