STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E147	A. BUILDING _____ B. WING _____	C 08/31/2011

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 000	INITIAL COMMENTS Complaint Investigation A partial extended survey was conducted. 1182355/IL53939 -no deficiencies 1182465/IL54077 - F250, F279, F323 1182451/IL54061 - no deficiencies	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide psycho-social interventions for 1 of 3 residents R1; R1 was assessed to have a history substance abuse to include alcohol, and controlled substance, a history of agitation, and criminal history to include burglary, and robbery. R1 was involved in an altercation with a co-peer R2, R2 was stabbed by R1 in the left arm Findings include: According to the facility's incident investigation report date 8/4/10, R2 was in the courtyard and was approached by R1 and cut R2 in the arm. According to R1's clinical record R1 has	F 250		9/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 250	Continued From page 1	F 250		

diagnosis of depressive disorder, paranoid schizo-affective disorder, and schizophrenia. According to the social history and assessment dated 7/19/11 R1 is identified with history of (substance abuse, illegal substance use, criminal behavior, and agitation).

Psychiatric assessment summary dated 7/19/11 also indicates that R1 would benefit from the substance abuse group for history of substance abuse.

According to R1's clinical record dated 10/13/10 involuntary discharge denotes R1 was drinking alcohol and kicked out a window in the facility and that R1 is agitated especially with staff.

According to R1's recent hospital record psychiatrc evaluation dated 10/13/10 denotes R1's problem list as auditory hallucinations, delusions, and disorganized thoughts and behaviors. Another recent hospitalization psychiatric evaluation dated 7/22/2011 denotes R1's present illness to include admitted to the hospital for detoxification, and that R1 admitted by interview that he takes marijuana and heroin The hospital record admitting diagnosis indicates drug addiction and detoxification.

According to nurses note dated 5/14/11 10:30pm denotes that R1 was assessed to have returned to the facility smelling of alcohol.

According to R1's clinical record dated 6/17/2011 background check indicates R1 with an extensive criminal history, and was identified offender low risk.

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F 250	Continued From page 2 According to R1's clinical record dated 7/29/11 current care plan there is no plan of care with interventions to address R1's behaviors of agitation, substance abuse, criminal history and/or identified offenders status. According to the psycho-therapeutic group listing R1 was not enrolled in any therapeutic groups to assist in the improvement of R1's psycho-social well being. On 8/9/2011 at 3:45pm, E10 (social service) said that he was aware of R1's behavior and history because R1 has been a resident on and off over the past year. E10 said that R1 was only here 10 days before the incident and the plan of care for R1's behavior had not yet been addressed. E10 said that the comprehensive plan of care should have been completed within 7 days of admission. E10 was unable to verbalize to the survey team why R1's behavior and history of inappropriate behavior was not addressed. E10 did say that R1's refusal of treatment and non-medication compliance was addressed. According to the facility's care plan policy denotes the care plan for new admissions will be done within the first seven days upon arrival. According to R1's clinical record R1 was admitted to the facility on 7/19/11. The policy also said that care plans are done based on medical forms obtained prior to admission, along with intake information.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop an interim plan of care for 1 of 3 residents R1 assessed with a history of substance abuse to include alcohol, and controlled substance, a history of agitation, and criminal history to include burglary, and robbery. R1 was involved in an altercation with a co-peer R2. R2 was stabbed by R1 in the left arm Findings include: According to the facility's incident investigation report date 8/4/10, R2 was in the courtyard and was approached by R1 and cut R2 in the arm. According to R1's clinical record R1 has diagnosis of depressive disorder, paranoid schizo-affective disorder, and schizophrenia. According to the social history and assessment dated 7/19/11 R1 is identified with history of (substance abuse, illegal substance use, criminal behavior, and agitation). Psychiatric assessment summary dated 7/19/11 also indicates that R1 would benefit from the substance abuse group for history of substance abuse. According to R1's clinical record dated 10/13/10 involuntary discharge denotes R1 was drinking alcohol and kicked out a window in the facility and that R1 is agitated especially with staff. According to R1's recent hospital record psychiatrc evaluation dated 10/13/10 denotes R1's problem list as auditory hallucinations,	F 281		

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F 281	Continued From page 4	F 281		

delusions, and disorganized thoughts and behaviors. Another recent hospitalization psychiatric evaluation dated 7/22/2011 denotes R1's present illness to include admitted to the hospital for detoxification, and that R1 admitted by interview that he takes marijuana and heroin The hospital record admitting diagnosis indicates drug addiction and detoxification.

According to nurses note dated 5/14/11 10:30pm denotes that R1 was assessed to have returned to the facility smelling of alcohol.

According to R1's clinical record dated 6/17/2011 background check indicates R1 with an extensive criminal history, and was identified offender low risk.

According to R1's clinical record dated 7/29/11 current care plan there is no plan of care with interventions to address R1's behaviors of agitation, substance abuse, criminal history and/or identified offenders status. According to the psycho-therapeutic group listing R1 was not enrolled in any therapeutic groups to assist in the improvement of R1's psycho-social well being.

On 8/9/2011 at 3:45pm, E10 (social service) said that he was aware of R1's behavior and history because R1 has been a resident on and off over the past year. E10 said that R1 was only here 10 days before the incident and the plan of care for R1's behavior had not yet been addressed. E10 said that the comprehensive plan of care should have been completed within 7 days of admission. E10 was unable to verbalize to the survey team why R1's behavior and history of inappropriate behavior was not addressed. E10 did say that

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F 281	Continued From page 5 R1's refusal of treatment and non-medication compliance was addressed. According to the facility's care plan policy denotes the care plan for new admissions will be done within the first seven days upon arrival. According to R1's clinical record R1 was admitted to the facility on 7/19/11. The policy also said that care plans are done based on medical forms obtained prior to admission, along with intake information. On 8/9/2011 at 3:45pm E10 (social service), said that he was aware of R1's behavior and history because R1 has been a resident on and off over the past year. E10 said that R1 was only here 10 days before the incident and the plan of care for R1's behavior had not yet been addressed. E10 said that the comprehensive plan of care should have been completed within 7 days of admission. E10 was unable to verbalize to the survey team why R1's behavior and history of in appropriate behavior was not address. E10 did say that R1's refusal of treatment and non-medication compliance was addressed. According to the facility's care plan policy denotes the care plan for new admissions will be done within the first seven days upon arrival. According to R1's clinical record R1 was admitted to the facility on 7/19/2011. The policy also said that care plans are done based on medical forms obtained prior to admission, along with intake information.	F 281		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		9/7/11

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F 323	Continued From page 6 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a plan to monitor and provide supervision for 1 of 7 residents (R1), all assessed as low risk identified offenders and assessed to require supervision and increased monitoring. R1 was allowed the most liberal community access which required no supervision. Subsequently R1 was able to bring a large hunting knife into the facility and stab a co-peer (R2) in the arm. R2 was taken to the emergency room for evaluation and was treated and required 9 sutures. The facility also failed to implement an emergency crisis plan with preventive measures to contain R1 after R2 was stabbed, and R1 was able to move throughout the facility and was not stopped until taken down by local police department. These failures resulted in an Immediate Jeopardy. These failures endangered all 111 residents residing at the facility on 8/4/11. E2 (Director of Nursing) was notified of the Immediate Jeopardy on August 16, 2011 at 3:35pm via telephone conference. The Immediate Jeopardy was determined to have begun August 4, 2011 when R1 stabbed R2 in the	F 323		

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arm. The Immediate Jeopardy was removed on August 23, 2011 at 5:00pm. E1 (Assistant Administrator), was present. However the facility still remains out of compliance at a scope and severity level 2 because of the need to allow for the facility to complete Nursing and staff in-service, training and to evaluate the effectiveness of the revised protocol to search identified offenders upon entering the facility, revised code brown and court yard monitoring policy and assessment for appropriate pass privilege policy and care plan updates.

According to R1's nursing notes dated 8/4/11 4:20pm, R1 was noted in courtyard 21 as cutting another resident (R2) with a knife. Both R1/R2 noted as separated and removed from the situation 911 called. Nursing note 8/4/11 4:38pm indicates that the local police arrived to the facility and transferred R1 to the hospital. The note indicates that R1's physician was notified. Nursing note 8/4/11 at 8:30pm indicates call placed to local hospital and R1 was still being evaluated. Nursing note 8/4/11 10:45pm indicates that the local hospital called and the facility staff informed that R1 was assessed to be intoxicated and cannot be evaluated at the present time. Nursing note 8/5/11 8:05am denotes that local hospital contacted and informed facility that R1 is being admitted to the facility for psychosis.

Social service note dated 8/4/11 indicates in courtyard 21 R1 approached co-peer R2 and cut him in the right arm with a knife. The note indicates that staff responded immediately and separated the two residents. The local police noted arriving to the facility and removed R1 from

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the premise, and took R1 to the local police department.

According to R1's clinical record dated 7/28/11 R1 was assessed with pass privilege 3 and able to be in the community independently. According to the facility's screening assessment for indicators of aggressive behavior and/or inappropriate behavior dated 7/19/11, R1 is assessed with a diagnosis of severe mental illness, history of substance abuse, and history of criminal behavior.

According to R1's social history and assessment dated 7/19/11, R1 was assessed to have a history of drug and alcohol use. Psychiatric assessment summary dated 7/19/11 also indicates that R1 would benefit from the substance abuse group for history of substance abuse.

According to R1's current plan of care dated 7/19/11 and 7/29/11 there are no care plans developed to address R1's history of substance abuse, no plan of care developed to address R1's history of criminal behavior, and no plan of care developed to address R1's assessment hallucinations, and/or history of suicidal ideations.

According to R1's physician order sheet R1 is diagnosed with depression, paranoid schizophrenia. R1's psychiatric evaluation dated 7/19/11 denotes affect of being flat, hallucinations and history of suicidal ideations.

R1's initial obra I screen denotes in part III R1 has been assessed with impaired cognition and/or behavioral functioning. It also identifies

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R1's history of psychiatric hospitalizations, and mental outpatient mental health services, and indicators to support mental illness. The screen indicates if any of these indicators are identified to complete section IV of the screen. Upon review of R1's screen, section IV of the initial screen was not presented to the survey team, and the determination and outcome summary report was also not provided to the survey team for review. The determination and outcome summary denotes what specialized psychiatric service are required, and the level of nursing care required.

According to R1's clinical record dated 6/2/11 R1 is assessed to be an identified offender. R1 is assessed to be a low risk offender, with requirements of supervision in an open facility. Behavioral changes suggest a need for closer observation should be noted and responded to according to facility procedure. According to R1's background check R1 is identified with felony offenses to include: theft, possession of a controlled substance on multiple occasions, burglary, and robbery.

According to the facility's incident investigation report dated 8/4/10, R2 was in the courtyard and was approached by R1 who cut R2 in the arm. The report indicates that staff immediately separated both residents and removed R2 from the situation. Staff evacuated the courtyard and secluded R1 from everyone else. The report indicates that the local police was contacted immediately and arrived and took R1 off the property. R2 is noted as receiving immediate care from nursing staff and ambulance arrived with local police and took R2 to the hospital for

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F 323	Continued From page 10 evaluation and treatment On 8/9/11 at 4:45pm E5 (certified nurse aide) said that on 8/4/11 she was doing 4:00pm rounds and R1 and R2 were in the alley talking, and said the conversation was getting loud. E5 said R2 yelled out that he was stabbed while running. E5 said she called 911. E5 said that she ran into the hallway to protect herself. E5 said that she went to the front of the facility and told other residents to get out of the way. E5 said she saw blood running from R2's arm and said that R1 had a large knife in his right hand. E5 said the knife was large and black about 6 inches long. E5 said she told R1 to calm down and then removed herself from the danger because E5 admitted she was scared. E5 said other residents were around. E5 said that she was unaware of crisis prevention E5 said that she was in the recreation room when the police arrived and was not around. E5 said she recalled seeing security but was trying to get out of the way. On 8/9/11 at 12:15pm R4 was assessed to be alert and oriented to person, place, and time. R4 said he was in the court yard but did not see R1 stab R2, but recalls a streak running by and then running around the picnic tables in the courtyard. R4 said that R2 was being chased by R1 around the tables. R4 said that he tried to grab R1 but he was swinging his arm with the knife. R4 said that R1 was yelling that everybody was against him, R4 said that R1 seemed intoxicated. R4 said that it was common for R1 to be intoxicated at the facility. R4 said he and other residents attempted to talk to R1, and the only staff present was E1 (administrator). R4 said that R1 ran and followed the blood trail left behind by R2. R4 said	F 323		

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that R1 ran from building 21 into building 15 and to the front door looking for R2. R4 said that R1 also chased another resident outside of the building swinging the knife at him. R4 said that as R1 was swinging the knife out in front of the facility at the other resident. R1 was then pushed down to the ground by the other resident. R4 said by this time the police came and asked R1 to drop the knife, but R1 would not drop the knife. R4 said that R1 was tazed twice by the police and then the police stepped on his right arm to remove the knife from R1. R4 said after the police removed the knife R1 was handcuffed by the police. R4 said there was no staff present and that residents were trying to take R1 down. R4 said the knife was large with a black blade about 5 to 6 inches in length. R4 said that he was scared. R4 said that R1 had a look in eyes that he wanted to kill someone.

On 8/9/11 at 12:50pm R5 was assessed to be alert and oriented to person, place and time. R5 said on 8/4/11 he was headed to the 21 courtyard, and saw R1/R2 talking. R5 said that he saw R2 running saying R1 stabbed him with a knife and ran into the building. R5 said that R2 ran from building 21 through building 15 toward the front of the building. R5 said that R1 had a knife in his right hand and started chasing other residents around the courtyard. R5 said the knife was large about 6 or 7 inches long. R5 said that R1 was intoxicated, said he saw R1 drinking on the corner earlier that afternoon. R5 said that he got out of the way because he was scared. R5 said that R1 chased him with the knife from building 21 through building 15 out the front door. R5 said that everybody was running around the courtyard as R1 was running swinging the knife.

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R5 said that R1 was yelling you are one of them. R5 said that R1 was pushed to the ground by another resident as R1 was swinging the knife. R5 said the police arrived and tried to get the knife from R1. R5 said that the police used tazers on R1 twice to get him to give up the knife. R5 said that no staff were present in the courtyard. R5 said that E1 and E5 had just left the courtyard when the incident occurred. E5 said that no staff attempted to stop R1, but other residents tried to stop R1.

On 8/9/11 at 11:30am R2 was assessed to be alert and oriented to person, place and time. R2 said that in the back of court yard 21 R1 approached him from behind and said that you said a lot of s__t about me. R2 said then R1 appeared to trip and as he tried to catch him R1 pulled a large black knife out and stabbed him in the left arm. R2 said that R1 appeared to be drunk with hallucinations. R2 said after he was stabbed he ran and R1 chased him around the court yard and then he ran into the building to the front door and went outside. R2 said that he did not recall seeing any staff in the courtyard during the incident. R2 said that no staff separated them or tried to stop R1. R1 said when he went outside the nurse came and wrapped his arm with guaze. R2 said the knife appeared to be a large hunting style knife about 6 -7 inches long. R2 said that he required 9 sutures at the hospital. R2 said after being stabbed blood was shooting out of his arm like water. R2 said that he saw E1/E6 (prsd) out front of the building after the police arrived. R2 said that the police used a tazer on R1 to get him to drop the knife.

On 8/9/11 at 12:00pm R3 was assessed to be

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alert, and oriented to person, place and time. R3 said that on 8/4/11 around 4:00pm he was in courtyard and saw R1/R2 in the back of the courtyard talking. R3 said he saw R2 running and R1 chasing behind him with a large knife in his hand. R3 said that R2 ran around the table and then into the building. R3 said that R1 then started stabbing the knife at other residents on the bench and table. R3 said that he was scared and that everybody was scared. R3 said that he did not recall any staff in the area. R3 said that R1 chased another resident into the building and said that he followed them out of the front door. R3 said that R1 took a swing at him with the knife and he pushed R1 to the ground. R3 said that R1 missed when he swung the knife at him. R3 said that the police came while R1 was on the ground and tried to get R1 to drop the knife. R3 said that R1 was holding the knife tight and the police use a tazer on R1 twice and stepped on his hand to get R1 to release the knife.

On 8/9/11 at 4:30pm E4 (assistant director of nursing) said on 8/4/11 at around 4:15pm he was making rounds and he heard code yellow (elopement) at building 15. E4 said that he came to the front of building 15 and he saw R1 with a large Rambo style black bladed knife. E4 said the knife was big, about 7 - 8 inches in length. E4 said that R4 is talking to R1 telling him to put the knife down. E4 said he stopped another resident coming in low position from behind R1. E4 said that R1 started toward him down the hallway of building 15 and he to started to back up. E4 said he told residents to go into the courtyard at building 15. E4 said that he backed into the court yard in building 15 and R1 followed. E4 said there were about 10 to 12 residents in the court

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yard. E4 said as R1 came into the courtyard he backed up. E4 said that R1 looked around the courtyard and took off running toward the front door. E4 said that was last that he saw of R1. E4 said that he went to enter the nurses station and that the door was locked, and staff was inside of the nurses station. E4 said that E6 (PRSD), E7 (nurse) along with other staff was locked in the nurse station. E4 said that he did not recall seeing the security guard at during the incident. E4 said he was not certified in crisis prevention. E4 said that other residents were trying to stop R1.

On 8/9/11 at 3:45pm E8 (receptionist) said that she recalls R2 running past the desk with his arm bleeding. E8 said that she recalls staff going the other way toward the courtyard, and recalls R1 coming to the front of building 15. R1 was yelling stay away from him poking the knife outward motion at other residents. E8 said that she recalls R1 running after R5 out the door in the front of the building and then R3 pushed R1 down to the ground. E8 said that the police came used a tazer on him and stepped on his arm to remove the knife. E8 said the security guard was present and tried to calm R1 down. E8 said that R1 was out of control and kept everyone away with the knife. E8 said she recalls seeing E4, but no other clinical staff. E8 said that R1 seemed intoxicated. E8 said that the knife was large blade knife but could not say how long it was.

On 8/9/11 at 3:15pm E7 (nurse) said that someone came to the nurse station and said that R1 had a knife. E7 said she did not recall who. E7 said she was told that he stabbed another resident. E7 said she saw R2 run out of the front

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door bleeding, said she went behind him and applied some 4x4's and wrapped with Kerlix to apply pressure. E7 said there was a lot of blood pooling and she could not see the wound. E7 said that as she went into the building she saw R1 with the knife, but did not want to make any eye contact with him and went into the nurses station. E7 said that she did not come out of the nurses station until the police came and took control of the situation. E7 said that she did call 911. E7 said R1 was holding a large knife in his hand. E7 denied knowing crisis prevention interventions.

On 8/9/11 at 1:00pm E6 (PRSD) said that she was in the courtyard when the incident occurred along with E1 and E5. E6 said that she recalls seeing R1/R2 talking in the back of the courtyard, then saw R2 run pass yelling this motherf____r is crazy. E6 said that she went to get help, called the receptionist to page staff, called social service office to call 911. E6 said that R2 ran past her out of the facility and E9 (PRSA) went outside along with E6. E6 said that she called 911 and went back to the courtyard. E6 said that she cleared other residents into the dinning room. E6 said that R1 came through building 21 yelling and cursing with a large knife. E6 said that R1 went outside in front of the building and tried to get back in and then the police came. E6 said that she was aware of R1's past history of EOTH (alcohol) abuse, illegal substance abuse and the assessment of being an identified offender and criminal analysis assessment of low risk. E6 said that R1 is a new admit and his medication non-compliance was addressed. E6 said that R1 did not seem intoxicated during the incident.

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F 323	Continued From page 16 On 8/23/11 at 11:00am via telephone E11 (security) said that he worked security on 8/4/11 during the incident involving R1/R2. E11 said that he was making rounds on the second floor of building 7 when he was called to building 21 courtyard. E11 said when he got to the courtyard E1 (assistant admin) was talking to R1. E11 said that he did not see a knife in R1's hand. E11 said since E1 was talking R1 he went back to the front of the building, and his job was to stop people from exiting and entering the building. E11 said that next time he saw R1 he was outside in front of the building, and that he did not see a knife. E11 said that he never saw R2 either but recalls seeing a pool of blood by the front door. E11 said that he was unaware of what crisis prevention was, and said that he has had no training. On 8/23/11 at 2:30pm E1 (assistant administrator) said on 8/4/11 she was in the 21 courtyard, and I saw R2 come over under tent holding his arm, I recall R2 saying that he was cut in the arm. Then I saw R1 come over to the tent area and he was holding a knife in his hand. E6 took R2 out the courtyard toward the front of the building. R1 was standing near me holding the knife outward and E1 said that she tried to reason with R1. E1 said that R1 sat on the bench for a moment then got up. E1 said that 911 was called and other staff came to the courtyard. E1 said that as R1 started walking from the courtyard into the building that a circle of staff surrounded him and tried to talk him down. E1 also said that there were residents trying to protect the staff. E1 said as R1 walked to building 15 he went into the courtyard. E1 said there were no residents in the courtyard at that moment. E1 said that after R1 went into the courtyard he came back in the	F 323		

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building and passed the nurses station and went outside. E1 said that as soon as he got outside R1 tried to come back into the building and E1 said that she told E8 to hit the switch to lock the doors. E1 said as soon as that happened the local police arrived and yelled at R1 to dropped the knife, but R1 would not and the local police used the tazer on him once to remove the knife. E1 described the knife as a fishing knife about 5-6 inches in length, and a serrated blade.

On 8/23/11 at 3:00pm E1 (assistant administrator) said that she and the staff did there best to protect the residents as well as themselves. E1 was unable to verbalize to the survey team any emergency action plans with interventions for residents who become physically aggressive, and endangers other residents.

It was confirmed through interview, observation, and record review that the facility took the following actions to remove the Immediate Jeopardy:

Immediate Corrective Actions:
At approximately 4:20 pm on August 4, 2011, Resident (JR) had an altercation with another resident, cutting resident (CH) in the left arm with a knife while in the 21 courtyard. At the onset of the incident, staff responded to the 21 courtyard and simultaneously intervened by: providing immediate medical attention to one injured resident (CH) to another location of the facility, communicating with resident (JR) to help moderate and dissipate his anger, prevent JR from causing further harm, remove other residents from harms way, and called 911 for

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F 323	Continued From page 18 immediate law enforcement assistance. Resident (JR) was removed from the facility by police and taken to Loretto Hospital and diagnosed with an acute psychotic disorder. Resident (JR) was discharged from the facility in police custody on Aug 4, 2011. Resident (CH) was taken to Loretto Hospital, treated, released, and transported back to the facility within 24 hours. Corrective Actions: On August 5, 2011, the day following the incident, the Social Service staff conducted a facility wide room search, in which no contraband materials, including items that can be used as weapons were found. [see enclosed] On August 12, 2011, The Director of Nursing developed and implemented a Code Brown Policy and Procedure and an Unmanageable Resident Policy Interpretation and Implementation and began in-servicing staff. [see enclosed] Beginning August 17, 2011, all staff will be in-serviced on How to Interact and Re-Direct Aggressive Residents. In-services will be completed by September 6, 2011. In-servicing will also be conducted for all new employees upon employment. [see enclosed] The Social Service Department, Security personnel will conduct weekly, random room searches of all identified offenders residing at Columbus Manor. A tracking form will be created by the PRSC to track any contraband found. Monthly audits of random searches will be audited by social service consultant on a monthly	F 323		

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basis to ensure compliance. Any resident in possession of contraband, including items that can also be used as weapons, will automatically be downgraded to Pass Privilege level 1 status (no outside community pass) and care planned accordingly. In addition, the facility will consider this resident for involuntary discharge.

CPI Training: To educate and better prepare the staff to intervene when conflicts arise, mandatory CPI Training for all clinical staff, social service, and security staff will be conducted by a certified professional, Ms. Diane McClain, beginning on August 31, 2011 and completed by September 7, 2011 and will be on-going for all new hires thereafter. CPI training consists of a 6-8 hour day of intensive instruction and hands on techniques.

The Social Service Department, Security Personnel, or their designees, will conduct body searches upon return from the community, home visit, etc., as outlined in the contraband policy attached. These searches will be performed by the front desk Security Personnel every time an identified offender, assessed as " low risk " , " moderate risk " , and " high risk " , by the IDPH criminal analysis report, enters the facility.

The above identified residents will be enrolled in the weekly Crimes and Consequence and Pass Privilege Groups.

The above identified residents have had their Pass Privilege Level decreased to a Level 2 status to limit their time in the community.

Any resident in possession of contraband, including items that can be used as weapons, will

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automatically be downgraded to Pass Privilege level 1 status and care planned accordingly (no outside community pass). In addition, the facility will consider this resident for involuntary discharge.

The Social Service Department will review any closed record of an identified resident re-admitted to the facility to better assist in the care planning process. Community access for those viewed as needing close supervision or close monitoring will be re-assessed and their community access restricted accordingly. Persons placing others at risk may be discharged from the facility according to idph standards.

Courtyard Policy: As stated in facility's policy, courtyard supervision will consist of:
1. CNA ' s will pass through and survey the courtyard during their hourly rounds on all shifts.
2. Security staff will pass through and survey the courtyard during their hourly round, opposite the hourly CNA round schedule.
3. Activity staff will provide monitoring from 12:00-12:30pm daily.
4. Front desk receptionist will monitor from the front lobby with a visual and auditory observation from 7:00am to 11:00pm and call for assistance as needed for interventions.
5. Front desk evening security guard will monitor 11:00pm-7:00am.
6. During courtyard cigarette pass times (7a, 9a, 11a, 1p, 3p, 5p, 7p,9p) The courtyard is supervised by staff for 20-30 minutes intervals.

Quality Assurance:

An emergency IDT meeting was held on Friday,

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F 323	Continued From page 21 August 5, 2011 that addressed aggressive behavior concerns. The Medical Director on staff was informed of the incident, by phone on Friday August 5, 2011. Instituting CPI Training was discussed with IDT and Medical Director. Behavior intervention strategies will be discussed during the weekly Risk Management meeting. A Behavior Occurrence Form will be maintained by the nursing department and discussed at both the weekly Risk Management and quarterly Quality Assurance meetings.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b)6) 300.3240a) 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	F9999		

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b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:
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
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to develop a plan to monitor and provide supervision for 1 of 7 residents (R1), all assessed as low risk identified offenders and assessed to require supervision and increased monitoring. R1 was allowed the most liberal community access which required no supervision. Subsequently R1 was able to bring a large hunting knife into the facility and stab a co-peer (R2) in the arm. R2 was taken to the emergency room for evaluation and was treated and required 9 sutures. The facility also failed to implement an emergency

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crisis plan with preventive measures to contain R1 after R2 was stabbed, and R1 was able to move throughout the facility and was not stopped until taken down by the local police department.

These failures endangered all 111 residents residing at the facility on 8/4/11.

According to R1's nursing notes dated 8/4/11 at 4:20pm, R1 was noted in courtyard 21 as cutting another resident (R2) with a knife. Both R1 and R2 were noted as separated and removed from the situation 911 called. Nursing note 8/4/11 at 4:38pm indicates that the local police arrived to the facility and transferred R1 to the hospital. The note indicates that R1's physician was notified. Nursing note 8/4/11 at 8:30pm indicates call placed to local hospital and R1 was still being evaluated. Nursing note 8/4/11 at 10:45pm indicates that the local hospital called and the facility staff informed that R1 was assessed to be intoxicated and cannot be evaluated at the present time. Nursing note 8/5/11 at 8:05am denotes that local hospital contacted and informed facility that R1 is being admitted to the facility for psychosis.

Social service note dated 8/4/11indicates in courtyard 21 R1 approached co-peer R2 and cut him in the right arm with a knife. The note indicates that staff responded immediately and separated the two residents. The local police noted arriving at the facility and removed R1 from the premises, and took R1 to the local police department.

According to R1's clinical record dated 7/28/11 R1 was assessed with pass privilege 3 and able

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to be in the community independently. According to the facility's screening assessment for indicators of aggressive behavior and/or inappropriate behavior dated 7/19/11, R1 is assessed with a diagnosis of severe mental illness, history of substance abuse, and history of criminal behavior.

According to R1's social history and assessment dated 7/19/11, R1 was assessed to have a history of drug and alcohol use. Psychiatric assessment summary dated 7/19/11 also indicates that R1 would benefit from the substance abuse group for history of substance abuse.

According to R1's current plan of care dated 7/19/11 and 7/29/11 there are no plans developed to address R1's history of substance abuse, no plan developed to address R1's history of criminal behavior, no plan of care developed to address R1's assessment hallucinations, and/or history of suicidal ideations.

According to R1's physician order sheet R1 is diagnosed with depression, paranoid schizophrenia. R1's psychiatric evaluation dated 7/19/11 denotes affect of being flat, hallucinations and history of suicidal ideations.

R1's initial obra I screen denotes in part III that R1 has been assessed with impaired cognition and/or behavioral functioning. It also identifies R1's history of psychiatric hospitalizations, and mental outpatient mental health services, and indicators to support mental illness. The screen indicates if any of these indicators are identified to complete section IV of the screen. Upon review of R1's screen, section IV of the initial

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screen was not presented to the survey team, and the determination and outcome summary report was also not provided to the survey team for review. The determination and outcome summary denotes what specialized psychiatric service are required, and the level of nursing care required.

According to R1's clinical record dated 6/2/11 R1 is assessed to be an identified offender. R1 is assessed to be a low risk offender, with requirements of supervision in an open facility. Behavioral changes suggest a need for closer observation should be noted and responded to according to facility procedure. According to R1's background check R1 is identified with felony offenses to include: theft, possession of a controlled substance on multiple occasions, burglary, and robbery.

According to the facility's incident investigation report dated 8/4/10, R2 was in the courtyard and was approached by R1 who cut R2 in the arm. The report indicates that staff immediately separated both residents and removed R2 from the situation. Staff evacuated the courtyard and secluded R1 from everyone else. The report indicates that the local police were contacted immediately and arrived and took R1 off the property. R2 is noted as receiving immediate care from nursing staff and ambulance arrived with local police and took R2 to the hospital for evaluation and treatment

On 8/9/11 at 4:45pm E5 (certified nurse aide) said that on 8/4/11 she was doing 4:00pm rounds and R1 and R2 were in the alley talking, and said the conversation was getting loud. E5 said R2

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yelled out that he was stabbed while running. E5 said she called 911. E5 said that she ran into the hallway to protect herself. E5 said that she went to the front of the facility and told other residents to get out of the way. E5 said she saw blood running from R2's arm and said that R1 had a large knife in his right hand. E5 said the knife was large and black about 6 inches long. E5 said she told R1 to calm down and then removed herself from the danger because E5 admitted she was scared. E5 said other residents were around. E5 said that she was unaware of crisis prevention. E5 said that she was in the recreation room when the police arrived and was not around. E5 said she recalled seeing security but was trying to get out of the way.

On 8/9/11 at 12:15pm R4 was assessed to be alert and oriented to person, place, and time. R4 said he was in the courtyard but did not see R1 stab R2, but recalls a streak running by and then running around the picnic tables in the courtyard. R4 said that R2 was being chased by R1 around the tables. R4 said that he tried to grab R1 but he was swinging his arm with the knife. R4 said that R1 was yelling that everybody was against him. R4 said that R1 seemed intoxicated. R4 said that it was common for R1 to be intoxicated at the facility. R4 said he and other residents attempted to talk to R1, and the only staff present was E1 (administrator). R4 said that R1 ran and followed the blood trail left behind by R2. R4 said that R1 ran from building 21 into building 15 and to the front door looking for R2. R4 said that R1 also chased another resident outside of the building swinging the knife at him. R4 said that as R1 was swinging the knife out in front of the facility at the other resident, R1 was pushed down

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to the ground by the other resident. R4 said by this time the police came and asked R1 to drop the knife, but R1 would not drop the knife. R4 said that R1 was tazed twice by the police and then the police stepped on his right arm to remove the knife from R1. R4 said after the police removed the knife R1 was handcuffed by the police. R4 said there was no staff present and that residents were trying to take R1 down. R4 said the knife was large with a black blade about 5 to 6 inches in length. R4 said that he was scared. R4 said that R1 had a look in eyes that he wanted to kill someone.

On 8/9/11 at 12:50pm R5 was assessed to be alert and oriented to person, place and time. R5 said on 8/4/11 he was headed to the 21 courtyard, and saw R1 and R2 talking. R5 said that he saw R2 running saying R1 stabbed him with a knife and ran into the building. R5 said that R2 ran from building 21 through building 15 toward the front of the building. R5 said that R1 had a knife in his right hand and started chasing other residents around the courtyard. R5 said the knife was large about 6 or 7 inches long. R5 said that R1 was intoxicated, said he saw R1 drinking on the corner earlier that afternoon. R5 said that he got out of the way because he was scared. R5 said that R1 chased him with the knife from building 21 through building 15 out the front door. R5 said that everybody was running around the courtyard as R1 was running, swinging the knife. R5 said that R1 was yelling you are one of them. R5 said that R1 was pushed to the ground by another resident as R1 was swinging the knife. R5 said the police arrived and tried to get the knife from R1. R5 said that the police used tazers on R1 twice to get him to give up the knife.

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R5 said that no staff were present in the courtyard. R5 said that E1 and E5 had just left the courtyard when the incident occurred. E5 said that no staff attempted to stop R1, but other residents tried to stop R1.

On 8/9/11 at 11:30am, R2 was assessed to be alert and oriented to person, place and time. R2 said that in the back of court yard 21 R1 approached him from behind and said that you said a lot of s__t about me. R2 said then R1 appeared to trip and as he tried to catch him R1 pulled a large black knife out and stabbed him in the left arm. R2 said that R1 appeared to be drunk with hallucinations. R2 said after he was stabbed he ran and R1 chased him around the court yard and then he ran into the building to the front door and went outside. R2 said that he did not recall seeing any staff in the courtyard during the incident. R2 said that no staff separated them or tried to stop R1. R1 said when he went outside the nurse came and wrapped his arm with guaze. R2 said the knife appeared to be a large hunting style knife about 6 -7 inches long. R2 said that he required 9 sutures at the hospital. R2 said after being stabbed, blood was shooting out of his arm like water. R2 said that he saw E1 and E6 (PRSD) out front of the building after the police arrived. R2 said that the police used a tazer on R1 to get him to drop the knife.

On 8/9/11 at 12:00pm, R3 was assessed to be alert, and oriented to person, place and time. R3 said that on 8/4/11 around 4:00pm he was in courtyard and saw R1 and R2 in the back of the courtyard talking. R3 said he saw R2 running and R1 chasing behind him with a large knife in his hand. R3 said that R2 ran around the table and

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then into the building. R3 said that R1 then started stabbing the knife at other residents on the bench and table. R3 said that he was scared and that everybody was scared. R3 said that he did not recall any staff in the area. R3 said that R1 chased another resident into the building and said that he followed them out of the front door. R3 said that R1 took a swing at him with the knife and he pushed R1 to the ground. R3 said that R1 missed when he swung the knife at him. R3 said that the police came while R1 was on the ground and tried to get R1 to drop the knife. R3 said that R1 was holding the knife tight and the police used a tazer on R1 twice and stepped on his hand to get R1 to release the knife.

On 8/9/11 at 4:30pm, E4 (assistant director of nursing) said on 8/4/11 at around 4:15pm he was making rounds and he heard code yellow (elopement) at building 15. E4 said that he came to the front of building 15 and he saw R1 with a large Rambo style black bladed knife. E4 said the knife was big, about 7 - 8 inches in length. E4 said that R4 was talking to R1 telling him to put the knife down. E4 said he stopped another resident coming in low position from behind R1. E4 said that R1 started toward him down the hallway of building 15 and he to started to back up. E4 said he told residents to go into the courtyard at building 15. E4 said that he backed into the courtyard in building 15 and R1 followed. E4 said there were about 10 to 12 residents in the courtyard. E4 said as R1 came into the courtyard he backed up. E4 said that R1 looked around the courtyard and took off running toward the front door. E4 said that was the last that he saw of R1. E4 said that he went to enter the nurses station and that the door was locked, and staff was

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inside of the nurses station. E4 said that E6 (PRSD), E7 (nurse) along with other staff were locked in the nurse station. E4 said that he did not recall seeing the security guard during the incident. E4 said he was not certified in crisis prevention. E4 said that other residents were trying to stop R1.

On 8/9/11 at 3:45pm, E8 (receptionist) said that she recalls R2 running past the desk with his arm bleeding. E8 said that she recalls staff going the other way toward the courtyard, and recalls R1 coming to the front of building 15. R1 was yelling stay away from him poking the knife outward motion at other residents. E8 said that she recalls R1 running after R5 out the door in the front of the building and then R3 pushed R1 down to the ground. E8 said that the police came, used a tazer on him and stepped on his arm to remove the knife. E8 said the security guard was present and tried to calm R1 down. E8 said that R1 was out of control and kept everyone away with the knife. E8 said she recalls seeing E4, but no other clinical staff. E8 said that R1 seemed intoxicated. E8 said that the knife was a large blade knife but could not say how long it was.

On 8/9/11 at 3:15pm, E7 (nurse) said that someone came to the nurse station and said that R1 had a knife. E7 said she did not recall who. E7 said she was told that he stabbed another resident. E7 said she saw R2 run out of the front door bleeding, said she went behind him and applied some 4x4's and wrapped with Kerlix to apply pressure. E7 said there was a lot of blood pooling and she could not see the wound. E7 said that as she went into the building she saw R1 with the knife, but did not want to make any

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eye contact with him and went into the nurses station. E7 said that she did not come out of the nurses station until the police came and took control of the situation. E7 said that she did call 911. E7 said R1 was holding a large knife in his hand. E7 denied knowing crisis prevention interventions.

On 8/9/11 at 1:00pm, E6 (PRSD) said that she was in the courtyard when the incident occurred along with E1 and E5. E6 said that she recalls seeing R1 and R2 talking in the back of the courtyard, then saw R2 run pass yelling this motherf____r is crazy. E6 said that she went to get help, called the receptionist to page staff, called social service office to call 911. E6 said that R2 ran past her out of the facility and E9 (PRSA) went outside along with E6. E6 said that she called 911 and went back to the courtyard. E6 said that she cleared other residents into the dinning room. E6 said that R1 came through building 21 yelling and cursing with a large knife. E6 said that R1 went outside in front of the building and tried to get back in and then the police came. E6 said that she was aware of R1's past history of EOTH (alcohol) abuse, illegal substance abuse and the assessment of being an identified offender and criminal analysis assessment of low risk. E6 said that R1 is a new admit and his medication non-compliance was addressed. E6 said that R1 did not seem intoxicated during the incident.

On 8/23/11 at 11:00am via telephone, E11 (security) said that he worked security on 8/4/11 during the incident involving R1 and R2. E11 said that he was making rounds on the second floor of building 7 when he was called to building 21

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courtyard. E11 said when he got to the courtyard E1 (assistant admin) was talking to R1. E11 said that he did not see a knife in R1's hand. E11 said since E1 was talking R1 he went back to the front of the building, and his job was to stop people from exiting and entering the building. E11 said that next time he saw R1 he was outside in front of the building, and that he did not see a knife. E11 said that he never saw R2 either but recalls seeing a pool of blood by the front door. E11 said that he was unaware of what crisis prevention was, and said that he has had no training.

On 8/23/11 at 2:30pm, E1 (assistant administrator) said on 8/4/11 she was in the 21 courtyard, and saw R2 come over under tent holding his arm. She recalled R2 saying that he was cut in the arm. Then she saw R1 come over to the tent area and he was holding a knife in his hand. E6 took R2 out the courtyard toward the front of the building. R1 was standing near E1 holding the knife outward and E1 said that she tried to reason with R1. E1 said that R1 sat on the bench for a moment then got up. E1 said that 911 was called and other staff came to the courtyard. E1 said that as R1 started walking from the courtyard into the building that a circle of staff surrounded him and tried to talk him down. E1 also said that there were residents trying to protect the staff. E1 said as R1 walked to building 15 he went into the courtyard. E1 said there were no residents in the courtyard at that moment. E1 said that after R1 went into the courtyard he came back in the building and passed the nurses station and went outside. E1 said that as soon as he got outside R1 tried to come back into the building and E1 said that she told E8 to hit the switch to lock the doors. E1 said

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F9999	Continued From page 33 as soon as that happened the local police arrived and yelled at R1 to dropped the knife, but R1 would not and the local police used the tazer on him once to remove the knife. E1 described the knife as a fishing knife about 5-6 inches in length, and a serrated blade. On 8/23/11 at 3:00pm, E1 (assistant administrator) said that she and the staff did there best to protect the residents as well as themselves. E1 was unable to verbalize to the survey team any emergency action plans with interventions for residents who become physically aggressive, and endangers other residents. (A)	F9999		