

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Annual Certification	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a plan of care to assess, and note signs and symptoms of constipation, and implement nursing interventions to reduce the risk of developing constipation for R30 of the supplemental sample, identified to have a history of constipation. These failure resulted in R30 being admitted to the hospital and was found to have a colonic and small bowel obstruction. Findings include: According to the R30's initial physical exam dated 2/25/10 the physician notes indicates R30 was admitted to the facility with a diagnosis of constipation. According to the R30's closed record physician order sheet dated May 1, 2011 through May 31, 2011 indicates a diagnosis of	F 309		12/15/11

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	<p>Continued From page 1 constipation.</p> <p>According to the nurses notes dated 5/5/11 2:00pm indicates that that R30 is observed lying in bed with loose, loose stools. The note indicates that R30 bowel movements were continuous. Nurse note 3:00pm indicates R30 again complaining of diarrhea, and R30's stomach is noted to be distended. The note indicates that R30's status will be endorsed to the 3:00pm to 11:00pm nurse. Nurse note 3:30pm indicates that R30 is alert and oriented, however R30's bowl are still moving and noted that the stools are very loose and coming out in large amounts. The note indicates that Z4 (physician) was in facility and gave orders to send R30 to the hospital for evaluation, R30 is noted being transported to the hospital for evaluation by outpatient ambulance service. Nurse note 5/6/11 2:00am notes that R30 is being admitted to the hospital for urinary retention and impaction.</p> <p>On 10/6/11/at 11:40am E15 (assistant director of nursing), said that it was reported to him by staff that R30 was barely eating food for about a 3 days to a week. E15 said that on 5/5/11 he saw R30 in his room with continuous loose greenish colored stool, that wouldn't stop. E15 said that R30's stomach was distended to the point that his skin was stretched. E15 said that other than observe that R30 had a distended stomach, he didn't listen for bowel sounds or perform any other assessments, nor did he check R30 for impaction or fecal obstruction. E15 said that something was wrong with R30, and said that staff were trying to get R30 transferred to the hospital for evaluation. E15 said that he didn't notify the physician when he was told by staff that</p>	F 309			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	<p>Continued From page 2</p> <p>R30, had poor food intake by mouth. E15 said that he couldn't recall what staff member told him that R30's food intake was poor. E15 also said he observed R30 eating and stated that R30 would barely take food in E15 said that R30 ate like a bird 3 days before he was sent to the hospital for evaluation.</p> <p>A review of the nurse notes dated 4/25/11 through 5/5/2011 there are no entries indicating R30's change in eating pattern, no entries notifying the attending physician that R30 eating behavior had changed. There were no nurses notes indicating that R30 abdomen was distended, and no entries documenting the attending physician was notified of R30's change in physical condition of an distended abdomen.</p> <p>On 10/6/11 at 11:15am E16 (nurse), said that she recalls being told by staff that R30 was having loose uncontrolled bowel movements. E16 said that E15 was present when she to take a look at R30. E16 said that E15 said he would assess R30 for fecal impaction. E16 said that she didn't see E15 perform the assessment, because she went to call the attending physician. E16 said that R30's abdomen was distended. However E16 said she assessed R30's vital signs, but didn't assess R30's abdomen for bowel sounds, and/or perform a digital rectal exam for fecal impaction. E16 said she recalls R30 clutching his stomach, and stating his stomach was hurting.</p> <p>According to R30's current care plan dated 3/16/11 there is no plan of care developed to address R30's diagnosis of constipation, and no nursing interventions developed to reduce the risk of constipation and/or assess for signs and</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 3 symptoms of constipations On 10/6/11/at 11:40am E15 (assistant director of nursing), after reviewing R30's care plan said that there were no other care plan available for R30. E15 was unable to verbalize why there was no plan of care developed noting signs and symptoms of constipation, and nursing interventions to reduce the risk of constipation. According to the CT scan of the abdomen and pelvic without contrast denotes the scan was indicated due to abdominal distention and pain. The scan impression indicated massively dilated rectum, and distal colon due to an extremely large quantity of dense stool in these locations consistent with constipation and distal colonic obstruction also resulting in some degree of small bowel obstruction, likely resulting in proctitis (inflammation of the anus and lining of the rectum).	F 309			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide grooming for 7 of 14 residents (R3, R4, R11, R12, R13, R15 and R16) reviewed for activities of daily living (ADL) concerns in the sample of 21.	F 312		12/15/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	<p>Continued From page 4</p> <p>Finding Includes:</p> <p>1. R4 was observed on 10/17/11 at 10:30am and 1:00pm wearing a white jack with multiple cigarette hole in front. The resident was also observed with dirty long cuticles and hair massed.</p> <p>R4 was also observe on 10/18/11 at 9:40am with dirty long cuticles and hair uncombed.</p> <p>The Minimum Data Sets date 09/15/11 denote section G0110 (G). Dressing was score 1/1 (Supervision- oversight, encourage or cueing/ setup help only) and (J). Personal hygiene was score 1/1.</p> <p>E 4 (Psych-Rehab Service Coordinator) on 10/18/11 at 11:00am stated," I notice the multiple burn hole in the jack.</p> <p>2. R13 was observed on 10/17/11 at 10:40am outside in courtyard 7 with house slipper on. The weather was approximately 60 degree. R13 has a body odor. She also was observed unkempt, uncomb and matted hair.</p> <p>3. On 10/17 and 10/18/2011 between 11:15am and 11:45am, R16 was receiving a lunch meal in the facility's dining area. R16 a male resident had long unkept hair and facial hair. On 10/19/2011, R16 was in the court yard/patio area between buildings seven and twenty-one. R16 wearing a winter cloth cap, had long unkept hair and facial hair.</p>	F 312			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 5 4. On 10/20/2011 at 9:37am, R15 was walking outside the facility wearing a pair of blue jeans, with multiple bleached spots on the right pant leg. The jeans length was just above the short boots, R15 was wearing. The jeans was not the right fit for this tall resident. On 10/18 at 11am, and 10/19/20110 at 12:18pm, R15 was wearing the same clothing. R15's jeans had a rubber band attached to the each pant leg. R15 appeared to be untidy at the time. R15's care plan lasted dated 5/17/2011 indicated R15 has a problem with refusing or residing bathing, wearing clean clothes, messy, unkempt appearance. The interventions include but not limited to: Involve the resident in a group appropriate to his deficits as related to poor self-care motivation. R15's listed programs do not address this issue. 5. R3, R11, and R12 were observed for three consecutive days on 10-17, 10-18, and 10-19-11 with long, dirty fingernails. When asked if they want their nails to be trimmed, R3, R11, and R12 replied that they would want their nails trimmed. Record review indicated that all three residents needed supervision and prompting in their ADL's including grooming. This condition was discussed on 10-19-11 at 3:15 P.M.during the Daily Status meeting with the facility staff. On 10-20-11, the nails of R3, R11, and R12 were observed trimmed.	F 312			
F 323	483.25(h) FREE OF ACCIDENT	F 323		12/15/11	

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 SS=E	<p>Continued From page 6 HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: A.) Based on observation, the facility failed to provide a hazard free resident environment. Cleaning solution left unattended. Standing water without signs.</p> <p>Findings Include:</p> <p>- 10/17/2011, at approximately 9:30am, a housekeeping mop bucket was observed outside of of resident room 07-8 filled with a cleaning solution. Inside the room, was a pale containing spray disinfectant, a one gallon unlabeled bottle of cleaning solution and a 32 ounce unlabeled bottle of cleaning solution, sitting on a table. E22 (Housekeeper) was located in resident room 07-7, out of visual control of both the mop bucket and pale of cleaning solutions.</p> <p>-10/18/2011, during the Environmental tour with E18 (Assistant Administrator) and E23 (Maintenance Tech) that started at 1:05pm, standing water was observed on the floor in front of the common shower/tub room in building 07, first floor.</p>	F 323			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 7</p> <p>-10/18/2011, during the Environmental tour with E18 and E23 that started at 1:05pm, an unlabeled pale of cleaning solution was observed at the door of resident room 01-06. E24 (Housekeeper) was not in the room. She then returned to the room from getting a light bulb. E24 confirmed that the pale had a cleaning solution in it and that she had left it unattended.</p> <p>B.) Based on observation, interview and record review, the facility failed to provide adequate supervision for 3 (R4, R15, R17) of 21 residents in the sample, when smoking.</p> <p>Findings Include:</p> <p>1. 10/18/2011, at approximately 10:15am, R17 was observed in Courtyard #15 (located between building #7 & #15) smoking cigarette butts. The resident was picking up one cigarette butt after another from the ground, lighting them from one butt to the next. On both hands, R17's thumb, index and middle fingers were burned (brown in color). The resident is not in the "Safe Smoking Program" therefore not monitored. At the time of the observation, no staff was in the courtyard. However, this courtyard can be observed from the lobby area where the receptionist desk is and the hallways belonging to building 7 and 15.</p> <p>10/20/2011, at approximately 1:30pm, R31 was observed picking up a lit cigarette from the ground in Courtyard #15 from the lobby. At the time of the observation, E20 (CNA) was sitting at the the receptionist desk located in the lobby. E20 stated that R31 was not in the "Safe Smoking Program" and did not have to be monitored while smoking. 10/18/2011, at approximately 11:45am,</p>	F 323			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 8</p> <p>E14 (Receptionist) was interviewed concerning his job functions. E14 did not say that he was responsible for monitoring residents smoking in the courtyard.</p> <p>2. On 10/19/2011 at 12:18pm, R15 was observed walking between the building seven and dining room area. The surveyor approached E6 (certified nursing aide) to inquire about R15's clothing. E6 accompanied the surveyor to find R15. R15 was on the patio area between buildings seven and twenty-one. R15 was requesting a light for a cigarette, from another resident (R13). E6 did not reply, if R15 was in the safe smoking program. E6 went to R15 to inquire why he was smoking the cigarette.</p> <p>R15 is listed as an unsafe smoker, in the facility's safe smoking group. This group requires resident to participate in a cigarette pass program conducted every two hours between 7am and 10pm each day, starting at the 7am hour. At the time R15 was smoking there was not cigarettes being distributed and no staff supervision. Also, this patio is visible from the nursing station (in building seven), reception area and windows in building twenty-one.</p> <p>3. R4 was observed on 10/17/11 at 10:30am and 1:00pm wearing a white jack with multiple cigarette hole in front. R4 was observed on the patio outside asking for cigarette. He was also observed picking up cigarette butts on the ground. R4 was observed with no staff supervising him smoking or picking cigarette butts off the ground.</p>	F 323			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 9 R4 was also observed on 10/18/11 at 9:40am outside on the patio asking for cigarette. R4 was also observed on 10/18/11 with no staff supervising him. The Minimum Data Sets dates 09/15/11 Section C1000 - Cognitive Skills for Decision Making score was 2 (Moderately impaired-decision poor: cues/supervision required. E4 (Psycho-Rehab Service Coordinator) on 10/18/11 at 11:00am stated , " They will call out for cigarette smoking time. He should be on a supervise smoking program."	F 323			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		12/15/11	

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 356	Continued From page 10 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to post the most current Staffing Schedule. Findings include: During the initial tour of the facility on 10/17/2011 and on 10/18/2011, the Staffing Schedule was observed posted in the facility lobby on the glass window. The posting included the total number and the actual hours by the licensed and unlicensed nursing staff directly responsible for resident per care per shift The posting, however, was dated 10/11/11 instead of 10/17/11 on Monday and 10/18/11 for Tuesday.	F 356			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/15/11	

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the dish machine is properly sanitizing dishes used to served 102 of 102 residents, receiving meals in the facility. Findings include: On 10/17/2011 at 11:40pm, E12 (dietary aide) was washing some of the dishes from the resident's lunch meal, using the facility's dish machine. E12 was asked to test dish machine for proper sanitation. E13 (cook/ supervisor) came into the area with chlorine chemical test strips in a container. E13 took one of the white strips and placed it on a dish, that came from the dish machine. The strip did not turn any other color. According to the container of the chlorine chemical test strip, a purple-blue color indicated the present of the chlorine sanitation solution. The surveyor checked the content of the container of chlorine base solution attached to the dish machine. This container had less than eight ounce of solution. E12 commented, there is no more container of the solution downstairs. The dish machine log book had strip in which the kitchen staff use to test the dish machine. The strip dated for 10/17/2011 for the breakfast was the color of white.	F 371			
F 406	483.45(a) PROVIDE/OBTAIN SPECIALIZED	F 406		12/15/11	

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406 SS=E	<p>Continued From page 12 REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide mental health rehabilitative programs that address identified problems, correlates with services from an outside sources, provides enough opportunities to develop skills, contains specific objective and goals and addresses discharge plan for 14 residents, (R15, R2, R10, R9, R16, R1, R7, R8, R5, R13,R3,R11,R12, and R14), in a sample of 21, all reviewed for mental health rehabilitative service.</p> <p>Findings include:</p> <p>1. On 10/17/2011 at 10:20am, R15 was verbally threatening to physically harm someone and cursing out loud. No resident or staff member was in the area at the time. On 10/18/201 9:30am, was present in the 33 building's floor hallway verbally threatening to physically harm someone and cursing out loud. An unknown housekeeper was present in the</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 13 area at the time.</p> <p>On 10/18/2011 at 11am, R15 was verbally threatening to physically harm both staff members and residents while in the line for the lunch meal. R15 was randomly approaching any person near him with a closed fist.</p> <p>On 10/18/2011 at 11:20am, E3 (psychosocial rehabilitate service director/PRSC) with E14 (reception) came to address R15's negative behavior.</p> <p>On 10/17 and 10/18/2011 R15 was not observed attending any of the facility's planned psychosocial service groups. No psychosocial groups were scheduled for 10/19/2011.</p> <p>According to listed planned groups, R15 is scheduled for safe smoking group and is listed as a participant in the passed cigarette programs. R15's other listed groups were Stress and Anger Management and Conflict Resolution groups.</p> <p>R15's care plan with the last date of 9/13/2011, R15 is to attend a day program twice a weekly. There is no documented common goal or objective for R15's skill program. None of the groups listed in R15's care plan address specific goals or objectives related to R15's attendance in the group.</p> <p>R15's nurse's progress notes had the following documented: -5/04/2011 at 1:30am, The resident attack the house keeper and tore off his shirt and hit him in the back of his head. The worker came running down the hall. When the nurse seen him running, she ask what is wrong and he gave her a report. Then the resident went into the TV (television) room and began fighting the resident. 4am,</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 14</p> <p>resident to have a direct admission to the hospital.</p> <p>-7/11/2011 at 9pm, Resident out to hospital for agitation.</p> <p>-8/03/2011 at 3:10pm, Resident up and about agitated, noted loud outbursts, and swearing.</p> <p>-8/25/2011 1:17pm, Resident up and about, verbally abusive, using profane language toward staff, voicing he will kill them all.</p> <p>-9/02/2011 at 8:45pm, Resident send out to emergency for evaluation for negative behaviors.</p> <p>-9/09/2011 Resident was re-admitted post hospitalization for</p> <p>-9/27/2011 1pm, Has been irritable most of the day. 1 to 1 attempted unsuccessfully. At this time he is very angry.</p> <p>On 10/19/2011 at 2:45pm, E3 (PRSD/case manager) report it was hard for R15, to attend group due to his disrupted behavior. R15 was going out to a day program but is not attending currently. R15 is not stable. There were no attendance records presented regarding any of R15's listed psychosocial groups. E3 was unable to provide evidence of what the facility did post R15's psychiatric hospitalizations (5/2011, 7/2011 and 9/2011) to adjust program interventions to prevention further negative behaviors.</p> <p>2. On 10/17/2011 between 10:15 and 11am, R2 reported not attending any type of groups. R2 reported what he does all day is stay in the room and watch television.</p> <p>On 10/17/2011 at 3:31pm and 10/18/2011 at 9:38am, R2 was present in the room, laying in bed. R2 was observed up and out of the room for the lunch meal between 11:15am and 12pm,</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 15 receiving a lunch meal.</p> <p>According to R2's medical record he is 32 year old resident original admitted to the facility on 7/08/2009.</p> <p>According to the facility's listed psychosocial groups, R2 is not listed for any. On 10/17/2011 at 11am, E3 (PRSD) reported the facility did not have any residents on a one to one psychosocial program.</p> <p>On 10/18/2011 at 1:18pm, E3 (case manager/PRSD) stated: R2 will not go to any groups. I think he would benefit from it. We tried the day program and he was not interested.</p> <p>On 10/20/2011 at 10:15am, E3 (PRSD) and E21 (activity director presented documentation regarding R2's attendance to psychosocial group and activity program. The documented reviewed between April and October 2011, had no current evidence of attendance for any activity or psychosocial groups. The Men's social group was discontinued in the month of June 2011.</p> <p>3. On 10/17/2011 3:15pm, 10/18/2011 at 9:30am and 10am, R10 was not engaged in any activities or psychosocial groups. On 10/17/2011 at 3:15pm, R10 voiced an interest to move to out the facility, but does not have a place to go.</p> <p>According to the facility's listed psychosocial groups, R10 is listed to attended: Conflict Resolution, Stress and Anger Management and Substance abuse. Each of these groups is scheduled to meet once a week for a thirty minute session. During the days of the survey, R10 was</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 16 listed for groups on 10/18 (Tuesday), 10/20 (Thursday) and 10/21/2011 (Friday). This is a total of one hour and thirty minutes of rehabilitative programing.</p> <p>On 10/18/2011 between 1:18pm and 1:26pm, E3 (case manager) reported R10 was placed in a substance abuse program, because during the last survey they were instructed to do so. The substance abuse group is not a MISA (mental illness substance abuse) group but a support group.</p> <p>4. R9 according to the medical record, was admitted to the facility on 1/07/2003. According to the listed psychosocial programs, R9 is scheduled to attend Human Sexuality and Safe smoking group with participation in passed cigarette activity. Also, R9 was scheduled to attend a day program twice a week.</p> <p>On 10/18/2011 at 1:31pm, E4 (case manager) reported R9 was not attending the day program lately. R9 needs constant reminder to go. R9 is in the human sexuality group because the state (state agency) said he should be in the group. E4 provided R9's group attendance records.</p> <p>R9's care plan dated 8/18/2011 listed R9 to attends the crimes and consequence group. In addition, the care plan does not outline any objective or goal for any of R9's assigned group. There is no goals to be achieved by R9 for attending the day program.</p> <p>The attendance record for the Human Sexuality and Safe Smoking groups, reflected R9 attendance on a weekly basis. This total one hour</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 17</p> <p>per week for rehabilitative services for R9. R9 had no attendance record for the crimes and consequence group.</p> <p>5. According to R16's medical record, R16 was originally admitted to the facility on 12/18/2003 and re-admitted on 8/10/2011. R16's care plan last dated 8/10/2011 does not address R16's unsuccessful discharge.</p> <p>On 10/19/2011 at 2:45pm, E3 (PRSD and case manager) reported R16 was discharged to the community and recently re-admitted to the facility. E3 reported the hospital record, had R16 was in the hospital for abnormal behavior after non-medication compliance. E3 was unable to explain why R16's current program does not address the reason for R16's unsuccessfully discharge.</p> <p>6. 3 of 4 days of the survey, R7 was observed wandering around the dining room in a white tee shirt and black shorts with a white strip.</p> <p>According to his pre-screening information, R7 is Developmentally Disabled.</p> <p>10/19/2011, during the Daily Status meeting, E3 (PRSD) stated that the facility has no psycho-social programing for the Developmentally Disabled.</p> <p>7. 10/17/2011, during the Initial tour of the facility, R1 was observed smoking in Courtyard #15. The resident admitted smoking in his room and not being caught by staff. 10/17/2011, at the 12 noon meal, R1 was observed taking chicken wings off of lunch trays that had been discarded by others. R1 said that he was still hungry and wasn't going</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 18</p> <p>to wait until everyone had been fed in order to get more chicken wings. Kitchen staff and CNAs were present in the dining room at the time of the observation.</p> <p>R1's psycho-social notes dated 6/20/11 and 7/18/11, contain incidents of physical altercations with other residents. Police had to be called in the 7/18/2011. R1 is an identified offender. He has an arrest that includes battery. R1 has a level 2 pass privilege. R1's care plans for behavior, smoking and identified offender dose not reflect any of these behavior.</p> <p>8. 10/17/2011, during the Initial tour of the facility R8 stated that she did not need any help with activities of daily living. "I do everything for myself. For activities I write letters to my relatives." R8 has a level 3 pass privilege meaning that she can stay out of the facility for up to 8 hours by herself. 3 of 4 of the survey, R8 expressed a fear of being put out of the facility and having to live on her own. R8 is not receiving any specialized rehabilitation concerning living in a less structured environment.</p> <p>9. R5 was observed on 10/17/11 at 11:30am and 2:00pm is very obesity. She was observed in the room lying in bed. She was not participating any exercise group program.</p> <p>R5 was observed 10/18/11 at 10:00am lying in bed. She was not participating exercise group program.</p> <p>R5 has diagnosis Schizophrenia.</p> <p>The health exercise program was observed on 10/18/11 at 10:00am. R5 was not participating in the exercise group program.</p>	F 406			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406	<p>Continued From page 19</p> <p>There no social services notes about resident exercise program and health eating program.</p> <p>The care plan 10/7/11 denote encourage resident to attend healthy eating and exercise program.</p> <p>E4 on 10/18/11 at 11:30am stated," She does not attend program in the facility. She should attend exercise and healthy eating program."</p> <p>10. R13 was observed on 10/17/11 1:00pm lying in bed. She was not participant any psycho social. R13 diagnosis schizophrenia and Atypical Psychosis.</p> <p>R13 was observed on 10/18/11 was observed out on patio smoking cigarette. She was observed on 10/18/11 at 1:30 pm sleeping in bed.</p> <p>R13 on 10/12/11 at 2:30pm stated, "I do not attend any program. "</p> <p>The care plan date 08/08/11 denote to prompt her to attend day program 2 x week and continue to notify her of the benefits of attending a day program.</p> <p>E4 on 10/18/11 at 10:30am stated," She is not any psycho social program."</p> <p>Surveyor: USCATEGUI, MARIA 11. In addition, review of the clinical records of R3, R11, R12 and R14 did not indicate that they attend Group Programs or other related rehabilitation services. These residents also were on the list of the residents who attend the</p>	F 406			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 406 F9999	Continued From page 20 in-house programs. The above resident was not attending the group program. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a)) 300.1210b) 300.3220f) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	F 406 F9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F9999	<p>Continued From page 21</p> <p>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:</p> <p>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to develop a plan of care to assess, and note signs and symptoms of constipation, and implement nursing interventions to reduce the risk of developing constipation for R30 of the supplemental sample, identified to have a history of constipation. These failure resulted in R30 being admitted to the hospital and was found to have a colonic and small bowel obstruction.</p> <p>Findings include:</p>	F9999			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F9999	Continued From page 22 According to the R30's initial physical exam dated 2/25/10 the physician notes indicates R30 was admitted to the facility with a diagnosis of constipation. According to the R30's closed record physician order sheet dated May 1, 2011 through May 31, 2011 indicates a diagnosis of constipation. According to the nurses notes dated 5/5/11 2:00pm indicates that that R30 is observed lying in bed with loose, loose stools. The note indicates that R30 bowel movements were continuous. Nurse note 3:00pm indicates R30 again complaining of diarrhea, and R30's stomach is noted to be distended. The note indicates that R30's status will be endorsed to the 3:00pm to 11:00pm nurse. Nurse note 3:30pm indicates that R30 is alert and oriented, however R30's bowl are still moving and noted that the stools are very loose and coming out in large amounts. The note indicates that Z4 (physician) was in facility and gave orders to send R30 to the hospital for evaluation, R30 is noted being transported to the hospital for evaluation by outpatient ambulance service. Nurse note 5/6/11 2:00am notes that R30 is being admitted to the hospital for urinary retention and impaction. On 10/6/11/at 11:40am E15 (assistant director of nursing), said that it was reported to him by staff that R30 was barely eating food for about a 3 days to a week. E15 said that on 5/5/11 he saw R30 in his room with continuous loose greenish colored stool, that wouldn't stop. E15 said that R30's stomach was distended to the point that his skin was stretched. E15 said that other than	F9999			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F9999	<p>Continued From page 23</p> <p>observe that R30 had a distended stomach, he didn't listen for bowel sounds or perform any other assessments, nor did he check R30 for impaction or fecal obstruction. E15 said that something was wrong with R30, and said that staff were trying to get R30 transferred to the hospital for evaluation. E15 said that he didn't notify the physician when he was told by staff that R30, had poor food intake by mouth. E15 said that he couldn't recall what staff member told him that R30's food intake was poor. E15 also said he observed R30 eating and stated that R30 would barely take food in E15 said that R30 ate like a bird 3 days before he was sent to the hospital for evaluation.</p> <p>A review of the nurse notes dated 4/25/11 through 5/5/2011 there are no entries indicating R30's change in eating pattern, no entries notifying the attending physician that R30 eating behavior had changed. There were no nurses notes indicating that R30 abdomen was distended, and no entries documenting the attending physician was notified of R30's change in physical condition of an distended abdomen.</p> <p>On 10/6/11 at 11:15am E16 (nurse), said that she recalls being told by staff that R30 was having loose uncontrolled bowel movements. E16 said that E15 was present when she to take a look at R30. E16 said that E15 said he would assess R30 for fecal impaction. E16 said that she didn't see E15 perform the assessment, because she went to call the attending physician. E16 said that R30's abdomen was distended. However E16 said she assessed R30's vital signs, but didn't assess R30's abdomen for bowel sounds, and/or perform a digital rectal exam for fecal</p>	F9999			

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F9999	<p>Continued From page 24</p> <p>impaction. E16 said she recalls R30 clutching his stomach, and stating his stomach was hurting.</p> <p>According to R30's current care plan dated 3/16/11 there is no plan of care developed to address R30's diagnosis of constipation, and no nursing interventions developed to reduce the risk of constipation and/or assess for signs and symptoms of constipations</p> <p>On 10/6/11/at 11:40am E15 (assistant director of nursing), after reviewing R30's care plan said that there were no other care plan available for R30. E15 was unable to verbalize why there was no plan of care developed noting signs and symptoms of constipation, and nursing interventions to reduce the risk of constipation.</p> <p>According to the CT scan of the abdomen and pelvic without contrast denotes the scan was indicated due to abdominal distention and pain. The scan impression indicated massively dilated rectum, and distal colon due to an extremely large quantity of dense stool in these locations consistent with constipation and distal colonic obstruction also resulting in some degree of small bowel obstruction, likely resulting in proctitis (inflammation of the anus and lining of the rectum).</p> <p>(B)</p>	F9999			