

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145850</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/08/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CEDAR POINTE REHAB &amp; NURSING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5825 WEST CERMAK ROAD</b> <b>CICERO, IL 60804</b>		
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F 323  F9999	Continued From page 26 through random direct care staff interviews on 4/1/13 am that the staff was knowledgeable and had understanding of the material that was presented by the administrative staff. There were no concerns with the information presented or the interviews conducted.  FINAL OBSERVATIONS  LICENSURE VIOLATION:  300.610a) 300.1210a) 300.1210d)3)6) 300.1220b)3) 300.3240a) 300.3240c) 300.3240d) 300.3240f)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.  Section 300.1210 General Requirements for Nursing and Personal Care	F 323  F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F9999	Continued From page 27  a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)  d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:  3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.  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.	F9999			

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F9999	<p>Continued From page 28 (Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011)</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</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. (Section 2-107 of the Act)</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)</p> <p>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a</p>	F9999			

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F9999	<p>Continued From page 29</p> <p>resident shall also report the matter to the Department. (Section 3-610 of the Act)</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) (Source: Amended at 15 Ill. Reg. 554, effective January 1, 1991)</p> <p>These regulations were not met as evidenced by the following:</p> <p>Based on observation, interview and record review the facility failed to protect one resident (R9) from being physically abused by another resident (R13) out of 5 residents reviewed for abuse and neglect in the sample of 16. The facility also failed to supervise and implement interventions to prevent one resident (R9) from being physically abused by another resident (R13) out of 5 residents reviewed for incidents and accidents in the sample of 16. This failure resulted in R13 physically assaulting R9 in three (3) different incidents. R9 sustained scratches to the face, an injury to the eye and a broken nose. After the first and second incidents, R13 remained in the facility on the same floor as R9.</p> <p>The facility was aware of R13's aggressive and</p>	F9999			

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F9999	<p>Continued From page 30</p> <p>violent behaviors after the first incident on 3/5/13 and R9's previous history of aggressive, violent behavior and current wandering behaviors. The facility failed to implement interventions to protect R9 and 18 other 4th floor residents with Dementia and wandering behaviors.</p> <p>Findings include:</p> <p>Admission Record documents R9 is a 75 year old male resident admitted to the facility on 2/27/13 with diagnosis of Dementia with Behavioral Disturbances. Nutritional Risk Review dated 3/8/13 documents R9 is 63 inches tall and weighs 126 pounds. Minimum Data Set (MDS) Section C, dated 3/5/13, Brief Interview for Mental Status scores R9 a 3 out of 15, R9 was unable to complete the interview for mental status, and has disorganized thinking. Section E does not document any behaviors or wandering. History and Physical dated 2/6/13 at the hospital prior to admission to the facility documents "acute delirium, agitation, and aggressive behavior."</p> <p>Admission Record documents R13 is a 59 year old male resident admitted on 9/21/12. Nutritional Risk Review dated 12/24/12 documents R13 is 68 inches tall and weighs 195 pounds. Minimum Data Set (MDS), dated 9/27/12, Section I lists diagnoses of Non-Alzheimer's Dementia, Schizophrenia, Schizoaffective Disorder Unspecified, and Nondependent Alcohol Abuse. Section C Brief Interview for Mental Status scores R13 as 11 out of 15 and does not have any behavior symptoms. MDS Section E dated 3/10/13 documents "Physical behavior symptom</p>	F9999		

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F9999	<p>Continued From page 31</p> <p>directed toward others scored as 1-behavior of this type has occurred 1 to 3 days." Maladaptive Behavior Check List dated 9/17/12 prior to admission to facility documents "20. noncompliance with medications and limited cognitive ability lead to poor judgement."</p> <p>R9 and R13 were involved in three incidents as follows:</p> <p>R13's Incident Report 3/5/13 at 4pm describes the incident as "Resident (R13) observed with another resident (R9) in his room and holding him down his hands on his back. Also observed him with a right sclera redness and a scratch on his left upper lip." Resident (R13) description is documented as "Resident alert x3 and aware wrongdoing." Immediate action taken by the facility is documented as "Redirected and separated. Smoking privileges removed. Meds given and taken well." No injuries were observed to R13. Other Information from the incident report documents "Resident (R13) alert and oriented times 3 and claim hitting this resident (R9) as he cannot take him out of the room." R13 does not have a care plan for aggressive, abusive or impulsive behaviors prior to this incident on 3/5/13. There is no evidence of a care plan being updated for these behaviors after the incident. R13 remained in the facility.</p> <p>R9's Incident Report 3/5/13 at 4pm describes the incident as "Resident (R9) observed by nurse aides in another resident's room (R13) being held down by him. Also observed with redness to his right sclera and a scratch on his left upper lip about 2 centimeters." Resident (R9) description is documented as "Resident confused." Injury</p>	F9999			

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F9999	<p>Continued From page 32</p> <p>Location is "right eye". Incident Report documents physician and family notification. Behavior Incident 3/5/13 documents R13 wandering in and out of rooms, has poor impulse control (argumentative, easily frustrated, defiant), is responding to others who are hostile, and has a limited attention span. Cause/Factor Conclusion statement documents "(R9) has a diagnosis of Dementia. He is alert with periods of confusion. He wanders into other residents rooms and goes through their belongings." R9 has a care plan with the focus "The resident is an elopement risk/wanderer resident wanders aimlessly, disoriented to place, significantly intrudes on the privacy or activity". R9 has a care plan initiated on 3/1/13 for verbally abusive and physical behaviors. There is no evidence that this care plan was updated after the incident.</p> <p>On 3/26/13 at 1:15pm E17 (Nurse) stated "On March 5th about 3:30-4pm, two aides brought the residents (R9 and R13) to the nurses station and I asked what happened. (R13) said he was the one who hit him; that he knew what he was doing. (R9) wanders all the time; it's not possible to constantly watch him."</p> <p>On 3/29/13 at 6:55am, by phone interview, E18 LPN (Licensed Practical Nurse) stated "I was working Friday night 3/8/13 into Saturday morning 3/9/13. (R13) hit (R9), this was the second incident between the two residents. I brought (R9) out to the nurses station for the rest of the night to monitor him. I notified the family and doctors. I called (E4) the Assistant Director of Nursing. (R9) is very confused and wanders all the time. (R9)'s eye was swollen and there was a scratch on his nose. After I cleaned it, there wasn't anything</p>	F9999			

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F9999	<p>Continued From page 33</p> <p>there that needed further treatment. " E18 stated that a third incident happened on 3/10/13 when (E17) (Nurse) was working. E18 was coming into work and (R9) and (R13) were both being sent out to the hospital. E18 stated " There were 3 incidents in that week."</p> <p>Review of the 24 Hour Nursing Reports for the 4th floor document "3/9/13 11pm-7am shift (R13) hit (R9)". Nurse Note 3/9/13 4:10am by E18 documents "I/C (incident charting) 1 of 3 resident sat at nurses station for observation most of the evening right eye slightly swollen only feels pain to touch neuro checks in progress at this time will continue to monitor safety maintained." E18 stated that as long as R9 sat at the nursing station, she was able to watch him. Otherwise, it is not possible to watch R9 all the time. The facility was unable to provide evidence of an incident report or an investigation.</p> <p>R13's Incident Report 3/10/13 at 11:20pm describes the incident as "Resident (R13) struck another resident (R9) in the face. Resident (R13) refuses to answer what happened." R13's mental status is assessed as oriented to person, place, time, and situation. Both the attending physician and psychiatrist were notified. R13 did not have a care plan for aggressive, abusive, or impulsive behaviors at the time of this incident on 3/10/13.</p> <p>R13 was transferred out of the facility for a psychiatric evaluation on 3/10/12, after the third incident. A care plan for the focus of "The resident is/has potential to demonstrate physical behaviors, physical aggression r/t Dementia, poor impulse control" is initiated on 3/20/13, upon readmission to the facility. R13 ' s care plan does</p>	F9999			



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F9999	<p>Continued From page 34</p> <p>not document any of the behavioral incidents on 3/5/13, 3/9/13, or 3/10/13.</p> <p>R9's Incident Report 3/10/13 at 11:19pm describes the incident as "Resident (R9) observed in another resident's room. Resident noted with vertical laceration to bridge of nose. Resident (R9) states someone hit him. Unable to further describe due to cognitive status." Physician and family were notified." R9 was transferred out to the hospital on 3/10/13 for a medical evaluation.</p> <p>On 3/28/13 at 12:10pm, E3 (Director of Nursing) stated "There were 3 incidents between (R9) and (R13)." E3 did not answer any more questions that were directed toward her about the incident between R9 and R13 on 3/9/13. E3 got up and left the conference room without answering any more questions. E2 (Assistant Administrator), E16 (Acting Administrator), and E19 (Director of Clinical Services) did not answer any of the questions related to an investigation, resident protection, or reporting of the incident between R9 and R13 in the early morning of 3/9/13. The facility did not present an incident report or any documentation for this incident that occurred on 3/9/13.</p> <p>Hospital CT (Computer Tomography) Scan Maxillofacial without contrast 3/10/13 "There is minimally displaced fracture of the right nasal bone with adjacent soft tissue swelling. There is a nondisplaced fracture of the anterior aspect of the left nasal bone."</p> <p>On 3/25/13 at 1:30pm at the hospital, R9 was asleep in bed. R9 is thin, with sunken cheeks. R9</p>	F9999			

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F9999	<p>Continued From page 35</p> <p>has a healing scar to the nose. R9 opened his eyes when name was called but did not participate in the conversation. At 1:35pm, Z6 (Hospital Nurse Aide) stated that R9 wanders constantly, needs to be fed, and is difficult to understand when talking. " We have to sit with him 24 hours a day because (R9) wanders all the time. If (R9) walks around, we go with him. " Z6 stated R9 wanders into other patient rooms at the hospital.</p> <p>On 3/26/13 at 1pm, R13 stated "He (R9) kept coming into my room. I had enough and hit him. I knew what I was doing."</p> <p>On 3/26/13 at 2:40pm, R17 stated "(R9) would come into our room all the time. He would go into everyone's room all the time. When (R9) came into the room, staff was never with him. They would come and get him sometimes. But other times, he was alone and he wouldn't leave."</p> <p>On 3/26/12 at 1:10pm, E20 (Dementia Unit Director) stated that wandering was part of R9's behaviors, "(R9) wandered all the time." R9 had severe dementia and was difficult to redirect. E20 stated R9 should have been supervised by all the staff on the 4th floor by "knowing his whereabouts". Staff should have visually seen him, do hall checks, and should have known where he was. E20 stated interventions would be one to one activities, keep R9 in eye sight, engage him in an activity, and offer food. E20 stated "There is no place to chart supervision." E20 explained that staff do not chart a wandering residents locations.</p> <p>On 3/26/13 at 4:20pm by phone interview, Z11</p>	F9999			

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F9999	<p>Continued From page 36</p> <p>(Physician) stated R9 is very demented, the incident on 3/10/13 was very aggressive, and R9 does not know what he is doing. " The staff needs to watch (R9) constantly. "</p> <p>On 3/26/13 at 4pm by phone interview, Z9 (Psychiatrist) stated R13 didn ' t like that R9 kept coming into his room. " I don ' t know why (R13) wasn ' t sent out after the first time " on 3/5/13, " (R13) should have been sent out. " Z9 stated that he only knew of the 2 incidents on 3/5/13 and 3/10/13.</p> <p>On 3/26/13 at 4:45pm by phone interview, Z14 (Psychiatrist) stated R9 does not know what he is doing due to dementia. Z14 was notified of the 2 incidents on 3/5/13 and 3/10/13. " Staff should have been watching him closely especially after the first incident knowing that (R13) has the aggressive and violent behavior. " Z14 explained that close monitoring would be occupying him with activities, watching where he is, keeping him out of other resident rooms.</p> <p>Nurses Notes for R9 from 2/27/13 through 3/10/13 document confusion, wandering behaviors, very hard to redirect, very confused. There is no evidence that the staff is supervising R9 with regard to wandering behaviors. The notes do not contain information of what the staff is doing to supervise and monitor R9. Nurse Note 3/2/13 documents " (R9) very confused-refuses to stay sitting in his wheelchair-gets up and walks ad-lib then he just stops and sits anywhere-gets into others beds-hard to redirect-physically abusive to staff-will continue to monitor. " There are no nursing notes for 3/3/13 or 3/4/13 monitoring R9 '</p>	F9999			

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(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 37</p> <p>s wandering behaviors.</p> <p>Nurse Note 3/5/13 documents R9 was found by CNAs in R13 ' s room, being held on his back by R13.</p> <p>Abuse Prevention Program Policy documents " Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Staff will identify residents with increased vulnerability for abuse. Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about, or suspect to the administrator or the person in charge of the facility acting on behalf of the administrator, or an immediate supervisor who must then immediately report it to the administrator. Residents who allegedly mistreat another resident will be removed from contact with other residents during the course of the investigation. The accused resident ' s condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility."</p> <p>R9 was transferred to the hospital on 3/10/13 per transfer/discharge sheet and nursing notes dated 3/10/13. R9 has not returned to the facility.</p> <p>R13 was transferred to the hospital on 3/27/13 per transfer/discharge sheet and nursing notes dated 3/27/13. Interview with E16, Assistant Administrator on 3/27/13 at 4:30 pm stated that R13 would be sent to a local hospital for psychiatric care and from there would be</p>	F9999			

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

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NAME OF PROVIDER OR SUPPLIER  <b>CEDAR POINTE REHAB &amp; NURSING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5825 WEST CERMAK ROAD</b> <b>CICERO, IL 60804</b>		
(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 38 transferred to the state psychiatric hospital that he was initially released from. On 3/27/13 at 5:33 pm R13 was observed leaving the facility via medical transport.  B	F9999			