STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003453	A. BUILDING: _____ B. WING _____	C 12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW REHAB & NURSING CENTER	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.3240a) 300.3240b) 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 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. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) These requirements are not met as evidenced by: Based on interview and record review the facility failed to protect one resident from physical abuse (R1) of eight residents reviewed for abuse in the total sample of eight residents. This failure	S9999		

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S9999	Continued From page 1	S9999		

resulted in R1 being physically abused by staff during an altercation when R1 was punched and kicked.

Findings Include:

R1 was admitted to the facility on 8/12/13 with diagnosis which include Bipolar Disorder, Depression, Schizoaffective Disorder and Substance Abuse.

Progress Note dated 10/31/13 at 3:18pm indicates that at 1:30 on that date R1 ripped electronic equipment from a co-residents room and when approached by staff became verbally and physically abusive and unable to redirect. Note indicates R1 punched a staff member in the face when staff intervened, tripped over bed covers and then fell face first onto the floor. R1 nose was bleeding bright red blood with bump to center of forehead. Treatment was applied to face and emergency medication given. R1 was then sent to local hospital for treatment.

Emergency Room Hospital History and Physical Report dated 10/31/13 at 3:08pm indicates R1 had blood in his nostril and change in mental status. R1 stated to hospital staff that he was punched by a staff member at the facility in his room by a Social Worker, E3 (PRSC/Psychiatric Rehabilitation Services Coordinator).
R1 denied falling but consistently stated that he was beaten by staff because he took electronic equipment that was not his.
Emergency Room (ER)Hospital Discharge records indicate both X-Ray and CT Scan negative for facial or skull fracture.

Progress Note dated 10/31/13 at 10:04pm indicates R1 returned to the facility alert and

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S9999	Continued From page 2	S9999		

verbally responsive, vital signs stable, denying any pain or discomfort.
Progress Note dated 11/1/13 at 7:50am indicated R1 slept throughout entire shift, voiced no concerns.

Progress Note dated 11/1/13 8:46 pm indicates R1 was seen by the psychiatrist and orders were given to send R1 to the hospital for a psychiatric evaluation. R1 left the facility at 6:02pm via ambulance.

Hospital ER History and Physical Report dated 11/1/13 at 9:16pm indicates R1 had a bruise on his forehead and face and right side of face lateral to right orbit (eye).

Hospital Psychiatric Discharge Summary dated 11/9/13 indicates R1 was discharged to another facility.
Attempt was made to contact R1 at the receiving facility however R1 had left the facility Against Medical Advice (AMA) and could not be reached for interview.

On 11/27/13 at 10:10am, during a confidential interview, it was reported that it was witnessed that E3 punched and kicked R1 on 10/31/13. It was further stated the supervisor was informed of this and she did not report it further and nothing was done. It was also stated that R1, E3 and E4 did not trip over covers on R1's bed but R1 was wrestled to the floor by E3. During this confidential interview it was also alleged that R11,R13 and R14 were also physically abused by E3.

On 12/3/13 at 2:10pm R9 (roommate of R1) stated "On 10/31/13 I was laying in my bed sleeping when I was aroused by E3's voice. R1

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S9999	Continued From page 3	S9999		

told something vulgar and profane to E3 and E3 replied 'You're gonna have to pay for it'. R1 then attacked E3. E3 then attacked R1 back, E3 threw multiple punches at R1 and then R1's face was bleeding. Then R1, E3 and E4 all wrestled to the floor and then I saw E3 and E4 kick R1 while he was down. The fight was still on and we were told to leave the room." R9 further stated no staff ever asked him about what he saw on 10/31/13 in his room and didn't come forward on his own because he was afraid of "being kicked out." R9 also stated "E3 wants to act like a cop. He's very dangerous."

According to nursing notes and hospital reports R1 did receive a bloody nose and bruises on and about his head and face after the altercation on 10/31/13.

Review of Employee Files indicated E3 had one allegation of physical abuse in his file in 10/2013 and was found to be unsubstantiated. E4 did not have any allegations of abuse on file, however did have a waiver for a battery charge not related to employment.

A group interview was conducted on 12/2/13 at 1:15pm. Ten residents were invited and six attended. R10, the Resident Council President was in attendance during the group meeting. All residents at that time stated they had not witnessed staff hit, kick, choke or otherwise physically or verbally abuse residents. R9 later stated that he did see E3 hit a resident with his knee once, and could only recall the residents first name. This information was immediately told to E1 who initiated an investigation. E3 was already on suspension due to allegation of physical abuse on 11/27/13.

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S9999	Continued From page 4 On 12/3/13 both E4 and E5 were suspended. On 12/4/13 E1(Administrator) and abuse coordinator stated that E3 had been terminated from employment and on 12/5/13, E1also stated that E4 had also been terminated due to substantiated findings of abuse. E1 further stated that it was E3 and E4 that told the story about tripping over the bed covers and falling to the floor with R1 during the incident on 10/31/13. E1 also stated that she was not aware until 12/4/13 that E3 and E4 had physically assaulted R1 during the altercation or that R10 was a witness in the room at the time. Facility Policy/Abuse Prevention Program dated 1999 indicates: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Physical Abuse includes hitting, slapping, kicking, and controlling behavior through corporal punishment. (B)	S9999		