

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER COLUMBUS MANOR RES CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5107 21 WEST JACKSON BOULEVARD CHICAGO, IL 60644
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1010h) 300.1210b) 300.1220b)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>Nursing and Personal Care</p> <p>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.</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>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>A. Based on observation, interview, and record review the facility failed to protect one resident (R3) out of 7 residents in the sample from sexual assault. R2 has a history of aggressive behavior and is identified for wandering into other residents room and rummaging through their belongings. This failure allowed R2 to enter a resident's room (R3) undetected and sexually assault her. This deficient practice has the potential to affect all 122 residents in the facility.</p> <p>Findings include:</p> <p>R3 is a 63 year old female resident with diagnoses including Schizophrenia and Anxiety disorder. R3 is alert and oriented to person, place and time.</p> <p>R2 is a 25 year old resident with diagnoses including Schizo affective disorder. R2 was admitted to the facility on 3/4/14 and had only been in the facility 8 days when this incident occurred.</p> <p>The incident report dated 3/11/14 at 9:05pm indicates R3 stated a male resident (R2) entered her room and touched her vagina.</p> <p>According to the hospital initial psychiatric evaluation dated 2/25/14, R2 resided at another long term care facility but was transferred out due to his very irritable, hostile and aggressive behavior, persecutory delusions and auditory hallucinations.</p> <p>On 3/25/14 at 11:00am, E3 (PRSC/psych rehab services coordinator) stated, "it happened in the evening. Nursing called me and said there was an incident. R3 reported a male (R2) had</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>inappropriately touched her. I believe it was her genital area. E2 (psych rehab services director) does the abuse investigations. We do a note for the 24 hour report and a note for the 5 day report."</p> <p>On 3/25/14 at 11:35am E4 stated, "the police did see him (R2) coming into her (R3's) room from the security camera."</p> <p>On 3/25/14 at 11:55am R3 stated, "on 3/11/14 at about 9:10pm a male resident entered my room while I was sleeping and I was awoken by him having his fingers inside my vagina. I started yelling and screaming. He ran out. I got up to put some clothing on and went to the guard's desk to report it. The guard (E6) took me back to the room to see if he was still there. The guard said I think I know who that is. He (R2) had bothered me sometime before. I forgot what he did because I was medicated. He (R2) told me earlier that day he was coming to my room and get me again. I sleep without clothing because I wet on myself and I don't have a lot to change in. He (R2) pulled my cover off of me and put his fingers inside my vagina."</p> <p>At 3:15pm E6 (security) stated, "there was an altercation we had to breakup in the dining room between other 2 residents. When I came back to the desk, R3 was coming to the desk crying and yelling, "that guy, that guy, he was in my room!" I said what guy? She said she didn't know his name. She described him to me but I couldn't make out who she was talking about. I told her let's go to her room to see if he was still in the area. He wasn't. I took her back to the lobby to sit with me. I told her to stay with me just in case he walks by. He walked past and she said "that's him!" I took R2 to the nurse's station. He's not</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>supposed to be in a females room unless invited. That's for all males before curfew, which is 8:00pm and 8:30pm on the weekends." E6 further stated, "it was reported one time that he went into another resident's room. I don't know if it was a male or female. He was redirected over the intercom. If he hadn't responded, one of us would have gone over to him. This situation had to be going on while we were tending to the altercation between the 2 other residents. "</p> <p>At 4:00pm E8 (certified nurse aide - CNA) stated, "I do rounds every hour. I did not hear her (R3) scream." Surveyors reviewed the nurse aides round sheet dated 3/11/14 with E8. When asked about the check marks, E8 stated, "my checks mean that I seen the resident. I would have been able to hear her screaming if she was screaming."</p> <p>At 4:15pm E9 (security) stated, "the CNA watched the monitor while we were away." E9 wasn't sure who the CNA was.</p> <p>The Social History and Assessment dated 3/4/14 indicates R2 was observed wandering in other residents rooms. No theft.</p> <p>The Screening Assessment for Indicators of Aggressive, Harmful and/or Inappropriate Behavior dated 3/4/14 R2 scored 14, the high end of moderate risk. The PRSC is to observe for aggressive, harmful or inappropriate behaviors. There is no evidence a care plan was developed to address this new behavior.</p> <p>The comprehensive care plan dated 3/10/14 indicates on 3/10/14, it was reported that R2 was going into others rooms looking in drawers or closets.</p> <p>The facility does not have any evidence of other</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>measures in place besides security guards and video monitoring to protect R3. For the date of this incident the facility is unable to provide documentation of who was watching the security camera when R2 entered R3's room and assaulted her.</p> <p>B. Based on record review and interview the facility failed to obtain a physical or psychiatric assessment for one resident (R3) out the sample of seven residents reviewed for abuse. R3 was sexually assaulted by a male resident (R2). Facility documentation does not show that medical treatment was provided or a psychological evaluation was done for R3 regarding the incident of 3/11/14.</p> <p>Findings include:</p> <p>R3 is a 63 year old female resident with diagnoses of schizophrenia and anxiety disorder. R3 is alert and oriented to person, time and place.</p> <p>On 3/25/14 at 11:55am R3 stated, "on 3/11/14 at about 9:11pm a male resident entered my room while I was sleeping and I was awoken by him having his fingers inside my vagina. I started yelling and screaming. He ran out. I got up to put some clothing on and went to the guards desk to report it. The guard (E6) took me back to the room to see if he was still there. The guard said I think I know who that is. He (R2) had bothered me sometime before. I forgot what he did because I was medicated. He (R2) told me earlier that day he was coming to my room and get me again. I sleep without clothing because I wet on myself and I don't have a lot to change in. He</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>(R2) pulled my cover off of me and put his fingers inside my vagina. I was never offered to see the doctor and I was told it's time to see the psychiatrist.</p> <p>The nurses notes dated 3/11/14 at 9:05pm indicate that R3 went to the desk and informed the guard that a male peer came into her room while she was sleeping. When she opened her eyes the male resident was touching her vagina. The nursing notes dated 3/11/14 through 4/2/14 for R3 do not indicate a physical assessment nor a psychiatric evaluation regarding this incident was done for R3.</p> <p>The physician's (Z1) note dated 3/13/14 indicates he saw R3, however there is no assessment or mention of the 3/11/14 incident.</p> <p>The nurse's note dated 4/2/14 at 7:30pm indicates R3 was sent out to the community hospital for a psychiatric evaluation due to allegations that a male resident took her breasts and pushed them together. Review of the complete hospital record, documents, and interviews of medical staff does not show evidence of R3 being examined for the physical assault that occurred on 3/11/14.</p> <p>The facility's Incident/Accident Report procedure indicates in part: 3) Take vital signs and assess condition of resident.</p> <p>9) Check resident frequently, carry out physician's orders for care, report follow-up needed for charge nurse on next tour of duty.</p> <p>The Change in Condition Or Status indicates in part:</p>	S9999		

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S9999	Continued From page 7 It is the policy of this facility to notify the resident, his/her attending physician and family or guardian of changes in the resident's condition and or status. All notifications must be made as soon as practical, but in no case shall such notification exceed 24 hours. <p style="text-align: right;">(A)</p>	S9999		