STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E506	A. BUILDING _____ B. WING _____	C 11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	7325 SOUTH EXCHANGE CHICAGO, IL 60649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1586175/IL81399 - F225	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

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.

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F 225	Continued From page 1	F 225		

with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to follow their abuse policy and report/investigate allegation of abuse for 1 of 3 residents (R1) all reviewed for abuse.

Findings include:

R1 was admitted to the facility 3/24/15 and currently has diagnoses that include Paranoid Schizophrenia.

On 11/17/15 at 12:30pm R1 stated that he was hit in the left eye with a phone at the nursing station on the 3rd floor by E4, Psychiatric Rehabilitation Services Coordinator (PRSC). R1 stated that he immediately reported the incident to a nurse and CNA (Certified Nursing Assistant) on the 2nd floor and to a CNA on the third floor. During the interview, R1 was anxious and preoccupied with obtaining his "trust fund" and requested to leave before the interview was completed.

On 11/18/15 at 9:25am R1 was calmer and agreeable to continue interview. At that time R1 stated that he was at the nursing station (on 11/8/15) with the nurse station phone receiver in his hand and E4, PRSC attempted to take the phone receiver away from him and that is when R1 got hit with the phone receiver on the side of his head near his left eye. R1 stated that he does

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F 225	Continued From page 2	F 225		

not believe E4, PRSD intentionally hit him with the phone and that it was an accident. R1 stated that it was still phone time and he should've been able to use the phone. R1 stated that "the next morning I talked to E1, Administrator on the nurses cell phone." R1 stated that after being on the phone with E1, Administrator he tried to take back the statement he made regarding being hit with the phone by E4, PRSC because he felt pressured. R1 stated that he felt pressured to give up his statement. R1 stated "They looked at the video and determined I didn't get hit, that it didn't happen that way." R1 stated that he feels safe around E4, PRSC and although E4 is not his actual case manager, E4 "is technically his case manager" at times his own case manager is not around. R1 stated that he would feel comfortable talking to E4.

On 11/17/15 at 12:45pm E4, PRSC stated that R1 was at the nurses station and trying to use the nurses phone after hours. E4 stated that phone hours are from 6 - 7pm. E4 stated that he took the base of the phone away from R1 and that R1 was still holding the phone receiver. E4 stated that R1 became angry that he couldn't call and dropped the phone. E4 denied hitting R1 with the phone. E4 stated that he notified E5, House Supervisor/Nurse of the incident and didn't chart (document) as his shift was just ending and he left the facility.

On 11/17/15 at 2:10pm E5 stated that she was called to the nursing unit where she saw E4 and R1 and that R1 was "wild and hyperverbal" stating "You (E4) hit me in the ear with the phone." E5 stated that E4 told her that he took the base of the phone from R1 when he tried to dial the phone. E5 stated that she assessed R1's face

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F 225	Continued From page 3	F 225		

and noted no redness anywhere on his head. E5 stated she then called E1,Administrator on her phone. E5 stated that R1 told E1 (while on speaker phone) that he was hit in the head on the side of his face by E4. E5 stated that E1 continued to talk to R1 on the phone and told R1 that the cameras in the building will be able to tell if he was hit or not. E5 stated that R1 just became upset and couldn't talk and recanted his story to E1 - actually stating that E4 did not hit R1. E5 stated that she didn't document the incident events because she considered it a false allegation by R1.

On 11/17/15 at 3:20pm E6, Licensed practical Nurse (LPN) stated that she was passing medications on the 2nd floor when R1 came and told her that E4 hit him in the eye. E6 stated that at that time she assessed R1's eye and found no redness or bruise. E6 stated that she heard R1 had been going through the building saying that a staff member hit him and that's when R1 came to her. E6 stated that she then called up to the third floor and talked to E4, PRSC. E6 stated that E4 told her that the phone dropped and someone (R1 or E4) went to pick it up and that's when R1 got hit in the eye. E6 stated that she then called E5, House Supervisor/LPN and told her that R1 was reporting being hit by E4 and at that time E5 stated that she would call E4 to see what happened. E6 stated that R1 left her floor and said he was going to see E1, Administrator or Security.

On 11/17/15 at 4:00pm E7, Certified Nursing Assistant (CNA) stated that she was in the hallway on the 2nd floor when she overheard R1 tell E6, LPN that while he was trying to use the phone on the 3rd floor someone hit him in his eye

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F 225	Continued From page 4	F 225		

with the phone.

On 11/17/15 at 4:30pm E8, CNA stated that when she returned to the 3rd floor she saw R1 and E4, PRSC still in the nursing station and then saw E4 "escorting" R1 back toward R1's room. E8 stated that shortly after R1 returned to the nursing station and wanted to call the police. E8 stated that she redirected R1 back to his room however does not know if he went there or to another floor.

Event Report dated 11/8/15 at 7:17pm indicates "Consumer (R1) presents with false allegations against staff.
No description of actual incident was found in progress notes, Event Report or 72 hour follow up.
No documentation of an investigation into R1's allegations were found or presented.

On 11/18/15 at 10:45am E1, Administrator stated that talking to R1 on the phone after the incident was their initial investigation and that once R1 recanted they didn't continue the investigation and didn't report the allegation to the State Agency. E1, Administrator stated that both her and E2, Assistant Administrator/Psychiatric Rehabilitation Services Director (PRSD) were on speaker phone with R1 at the same time.

On 11/17/15 at 1:05pm E2, Assistant Administrator/Psychiatric Rehabilitation Services Director (PRSD) stated that R1's allegation was initially an abuse allegation "But he (R1) recanted while we were on the phone."

On 11/18/15 at 12:45pm E2, Assistant Administrator/Psychiatric Rehabilitation Services Director (PRSD) stated that E4, PRSC

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F 225	Continued From page 5	F 225		

immediately left the building after notifying E5, House Supervisor/LPN of the incident as his shift was over, however E4 did return the next day for his scheduled shift and was not suspended. E2 stated that they (Administration) had not yet looked at the video when they were talking to R1 on the phone after the incident but R1 thought they had.

Facility Abuse prevention Program/Facility Procedures dated 2012 indicates:

Internal Reporting Requirements and Identification of Allegations
Reports should be documented and a record kept of the documentation.

Protection of Residents
The facility will take steps to prevent potential abuse while the investigation is underway.
Employees of this facility who have been accused of abuse, neglect, mistreatment or misappropriation of resident property will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator.

Internal Investigation
All incidents will be documented, whether or not abuse, neglect, mistreatment or misappropriation of resident property occurred, was alleged or suspected.
Any incident or allegation involving abuse, neglect, mistreatment or misappropriation of resident property will result in an investigation.
The investigator will report the conclusions of the investigation in writing to the administrator or designee within 5 working days of the reported incident.

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F 225	Continued From page 6 The final investigation shall include the following: The Original Allegation (note day, time, location, the specific allegation, by whom, witnesses tot eh occurrence, circumstances surrounding the occurrence and any noted injuries. External Reporting Initial Reporting of Allegations When an allegation of abuse, neglect, mistreatment, misappropriation of resident property has occurred, the Department of Public Health's regional Office shall be informed immediately by phone or fax.	F 225		