

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000137</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/15/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOSTER HEALTH &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2840 WEST FOSTER AVENUE CHICAGO, IL 60625</b>
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S9999	<p><b>Final Observations</b></p> <p>Statement of Licensure Violation: 1 of 1 Violation:</p> <p>300.610a) 300.1210b) 300.1210d)3) 300.3240a) 300.3240f)</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 300.1210 General Requirements for 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</p>	S9999	<p><b>Attachment A</b></p> <p><b>Statement of Licensure Violations</b></p>	
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Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/04/19

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S9999	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>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.</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. (A, B) (Section 2-107 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)</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents are free of abuse, by failing to implement measures to protect a resident from resident-to-resident abuse, for one of three sampled residents (R1). As a result, R1 experienced psychosocial harm from being verbally and physically threatened by R2.</p> <p>Findings Included:</p> <p>R1 was a 40 year old resident, admitted to facility on 9/14/2018 with diagnoses that included Depression and Anxiety Disorders. On review of the Minimum Data Set (MDS) dated 12/11/2018, the resident's mental status was intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. According to the MDS, the resident had no behavioral issues and able to ambulate independently. R1 was identified to have a history of drug abuse. R1 weighed 147 pounds and was 5 feet 7 inches tall.</p> <p>R2 was a 41 year old, who was admitted to the facility on 2/1/2018, with diagnoses that included Depressive Disorder and Nicotine Dependence. On review of the Minimum Data Set (MDS) dated 11/26/2018, the resident's mental status was intact, as noted in her Brief Interview for Mental Status (BIMS) score of 15 out of 15. She weighed 253 pounds and was 5 feet 9 inches tall. Her MDS did not address any behavioral issues;</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>however her care plan noted behaviors of manipulative behavior expressed by anger and depression.</p> <p>On 2/13/2019 at 10:30 AM, R1 ambulated independently with steady gait in hallway. She was alert and oriented times three. There were three small areas of scab formation on the frontal side of the neck area. She began the conversation about the incident against her by R2 in a low toned manner. Her voice elevated and her hands began to shake. She said, "I am so terrified of what happened that when I speak about it my anxiety is worse". Surveyor ended the conversation at that time.</p> <p>On 2/13/2019 at 11:30 AM, R1 said R2 came into her room on 1/27/2019 at around 5:30 PM-6:30 PM and dragged her out by her neck holding on to her hoodie until R1 was able to wiggle out of her hoodie and screamed as she ran back to her room. She said she ran outside, when she saw two officers come into the building. She said nothing was done to prevent another such situation.</p> <p>On 2/14/2019 at 10:24 AM, R1 explained what happened against her by R2. She said she was afraid of R2 since she was here at the facility and had reported to V1 (Administrator) on several occasions about little things like verbal abuse of R2 towards her. According to her, R2 continued with her behavior. R1 said she was so afraid of R2 that she did not sleep well and would place the nightstand behind the door of her room after 1/27/2019.</p> <p>R1 reported on Thursday (1/31/2019) after the incident, V1 and V8 (Owner) came into her room and told her they were trying to put R2 out of the building, but it was a process.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>On 2/14/2019 at 10:15 AM, R1 said on 2/2/2019 in the morning between the hours of 10:00 AM and 11:00 AM, R2 approached her outside of the facility and grabbed her arm so tight where the fistula for her Dialysis was located, that her arm was sore for at least a week. R1 said she ran into the building screaming and the nurse called the police. She said she needs to speak with someone to get rid of the fear.</p> <p>On 2/14/2019 at 1:30 PM, R2 came to the facility and when R1 saw her, she ran in fear to V1's office who called the police.</p> <p>On 2/15/2019 at 10:45 AM, the surveyor called the local police department and confirmed that a call was made from the facility about residents fighting on 1/27/2019 at 7:00 PM and two officers came to the facility.</p> <p>On 2/14/2019 at 11:40 AM, V3 (Nurse) said R2 was always loud and aggressive and the staff had spoken with V1 (administrator) about her behavior but nothing was done. She (V3) said on 1/27/2019 she was on duty, but did not see or hear any altercation between R1 and R2. However, she said there was no intervention to prevent R2 from doing the same thing to R1 or any other resident.</p> <p>On 2/14/2019 at 11:55 AM, V2 (Director of Nursing/DON) said she was not aware of the incident of 1/27/2019, however, she said she knew about the incident on 2/2/2019 and R1 and R2 were scheduled to be sent out to community hospital for medical evaluation and psych evaluation respectively. V2 stated that R2 left Against Medical Advice (AMA) from facility on 2/2/2019.</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>Facility's policy on Abuse dated 11/2017 documented," Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches and considering his or her safety as well as the safety of other residents. The facility will also take steps necessary to ensure the safety of residents".</p> <p>The facility policy also included, "Any incident or allegation of abuse neglect, exploitation, mistreatment will result in an investigation". The facility was not able to present any documentation of an investigation.</p> <p>The policy also stated that, "The facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal conviction". The facility was not able to provided evidence that a criminal background check was conducted.</p> <p style="text-align: right;">(B)</p>	S9999		
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