

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/03/2020
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NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
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S 000	Initial Comments Complaint: 2086505/IL 125887 - F600G & F689G cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/21/20

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S9999	<p>Continued From page 1</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</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>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.</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>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a 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</p>	S9999			

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S9999	<p>Continued From page 2</p> <p>other residents and employees of the facility. (Section 3-612 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to 1) implement appropriate measures to ensure adequate supervision was provided for three (R5, R13 and R14) reviewed for physical abuse. 2) the Facility failed to protect the right to be free from abuse for two residents (R5 and R14) reviewed for abuse. This failure affects R5 and R14 who were physically abused. R5 was pushed down and sustained bruises, lip injury, generalized pain. R5 stated "he was afraid for his life at the time".</p> <p>Findings include:</p> <p>On 8/31/20 at 10:23am, R5 was noted on the 3rd floor hallway standing by his room. R5 stated he would like to talk to the surveyor about how another resident hit him in the back and on the head on 8/8/20 without any provocation. R5 stated he was waiting for his medication when it happened and he suffered bruises, swollen, busted lips and pain all over his body. R5 stated he was afraid for his life at the time but not anymore because the resident is now at the hospital. R5 identified the resident as R13. R5 stated the facility did nothing when it happened. R5 stated R13 had injured another resident which R5 identified as R14.</p> <p>R5's medical record progress note dated 8/8/20, V13 LPN (Licensed Practical Nurse) documented the incident that showed that R5 was attacked as was described by R5. V13 documented that R5 was pushed down, with bruises noted to left knee</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>and lips. R5 had pain scaled at 8/10 (Eight out of Ten with 10 being the worse pain).</p> <p>On the same day on 8/8/20, R13 physically assaulted R14 without provocation by hitting him in the back and another staff member was hit in the head on the same day.</p> <p>On 9/2/20 at 9:52am, interview with V19 PRSC (Psychiatrist Rehabilitation Services) V19 explained that R13 can be physically and verbally aggressive towards male co-peers. V19 stated some how R13 made his way to the basement of the facility and she was surprised to see R13 because he was on 1:1 supervision. V19 stated that R13 was on 1:1 supervision with a PRSA because he had hit R5. V19 stated R13 was talking to her in her office when R13 hit R14 in the back. V19 was unable to present the name of the facility staff that was in-charge of 1:1 with R13 on 8/8/20. V19 was unable to provide any 1:1 documentation pertaining to R13 from 8/6/20 to 8/8/20.</p> <p>On 8/31/20, V2 DON (Director of Nurse's) identified the resident as R13 and stated he is now on admission at the local hospital. V2 identified V1 (Administrator) as the abuse coordinator. When V1 was asked about what investigation was done and whether it was reported to the State Agency, V1 replied it was V20 (Social Service Director) who was in charge of faxing abuse investigations. V2 told the surveyor that she will have to go and look for the paper work in his office because V20 is no longer working at the facility.</p> <p>On 9/2/20, V2 presented, a facility Preliminary Incident Report completed by V19 which showed that R13 physically abused R5 and R14 on the</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>same day. The report indicated that it should be faxed to the State Agency. The report showed that R5 was injured and bruised and had swelling to right side of the forehead.</p> <p>On 8/31/20 at 1:30pm, the facility was unable to present any documentation of reporting this incident to the State Agency or that any investigation was done. V1 was unable to show how the facility notified the State Agency.</p> <p>On 9/1/20 at 10:28am, review of R14's electronic medical records showed that R14 was hit in the back of the head without provocation but no injury recorded.</p> <p>On 9/2/20 at 11:14am, V2 DON (Director of Nurse's) stated the facility didn't have a supervision policy addressing at risk behaviors.</p> <p>The Facility Policy Regarding at Risk Behaviors presented dated 11/2013 pointed out under procedure guideline that includes but not limited to making sure that person presenting the harmful behavior will be monitored and placed under 1:1 monitoring and it will not be discontinued until the behavior has subsided. The resident will remain on 1:1 until discontinued.</p> <p>The facility abuse Prevention Program policy presented with no date pointed out under policy statement that the facility residents have the right to be free from and abuse that includes but not limited to physical abuse. The policy documented under the Policy Interpretation and Implementation that the residents will be protected from abuse by anyone including and not limited to other resident or any other individual, identify and assess all possible incident of abuse and investigate and report any</p>	S9999		

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S9999	Continued From page 5 allegation of abuse with time frames by the federal requirements. (A)	S9999		
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