STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. BUILDING _____ B. WING _____	C 09/16/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERNATIONAL VILLAGE	**4815 SOUTH WESTERN AVE CHICAGO, IL 60609**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS C/O 0484004 & 0484214 LICENSURE VIOLATIONS 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with	F9999		

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F9999	Continued From page 20 each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.3240 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 300.3240 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. 300.3240 e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a Long Term Care facility is the perpeprator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. Based on review of abuse investigations, policy review, record review, staff interviews and review of staffing the facility failed to assure that one resident (R19) is free from physical abuse. Findings Include: While completing a record review on R19, nurses notes were reviewed. Nurses note dated 07/07/ 04 at 11:05p.m. state resident was noted with left	F9999		

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eye discolored and bluish. Doctor called with no response. R19 did not complain of pain and could not explain what happened to his face. Notes indicates vital signs were normal and showed no problems with range of motion. Notes also indicate R19 was getting into everything. Nurses notes state physician ordered X-ray of head and facial bones. During interview on 08/ 26/04 E3, Director of Nurses, was interviewed and surveyor requested investigation of above injury. E3 stated an investigation had not been done.

Nurses notes of 06/01/04 at 5:25p.m. written by E 15, Assistant Director of Nurses (ADON), state R 19 noted to have several bruises on upper body, green in color. R19 unable to explain mark on chest. Vital signs were normal and R19 did not complain of any pain. R19 to be monitored. There were no further nurses notes regarding these bruises.

Social service notes were also reviewed and note of 05/29/04, (no time), stated Social services (E 20) conducted a one to one assessment with R19 to discuss allegation of abuse by staff member. R19 was unable to provide and account of the incident. There were no marks or bruises on his body, refer to nursing notes for further details. Staff will continue to monitor his physical and mental well being. During interview on 08/26/04 E20 stated she worked the evening of 05/29/04. On 09/13/04 it was confirmed with E16, Director of Human Resources, that E20 was not on duty the evening of 05/29/04 and was not in the building that evening.

On 08/26/04 at approximately 5p.m. surveyors

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F9999	Continued From page 22 requested interviews with E1, Administrator, and E3, Director of Nurses. E1 and E3 were questioned at to the above social service note and did not recollect this incident. E1 and E3 stated they would review incidents. Surveyors requested any investigation of this incident. Surveyors were presented a incident summary of a witnessed physical abuse of R19 by E19 on 05/29/04 at 10:50p.m. on the third floor unit. Surveyors requested staffing schedules for 05/29/04 through the month of June 2004. Surveyors were presented with investigation of this incident dated 06/01/04 and staffing schedules. Surveyors were presented with a Preliminary 24 hour Incident Investigation Report for this incident which is not dated but was faxed to the Department's local office on 06/01/04 at 3:30p.m. Final Report was completed on 06/04/04, allegation of abuse was substantiated and E19 was terminated due to physical abuse of a resident. While reviewing all information regarding investigation there were two written statements dated 05/30/04 from E22 and E23 (Certified Nurses Aides) who witnessed the alleged abuse. Both wrote that on 05/29/04 at 10:30p.m., E22 and E23 were providing care to a resident when they heard loud noises in the hall. They witnessed E19 slamming R19 into a wall and was cursing him for taking a pop off his medication cart. R19 tried to get away and E19 followed him pushing him almost to the floor. R19 cursed at E 19. E19 came behind R19 pushing and shoving him and grabbing the collar of R19's shirt and slammed him again against the wall telling him never to put his hands on anything that doesn't	F9999		

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belong to him or he'll see what will happens next time. E22 and E23 walked R19 to his room where he took off his clothes and appeared very scared and said he thought he was going to kill me. Both staff stayed with R19 to help him calm down and stop shaking.

Review of May 2004 staffing schedules revealed that E19 continued to work on the third floor, 3p. m. to 11p.m. shift, on 05/30/04 and 05/31/04 in direct contact with R19 after alleged incident.

Facility policy states Nursing and Social Service personnel are responsible for initiating interventions to protect the resident from any further abusive acts while any reported incidents are be investigated. This may include staff suspension.

Incident report is dated as completed on 05/29/04 at 11:15p.m. by E18, Licensed Practical Nurse (LPN) and Minimum Data Set (MDS) coordinator. Summary indicates incident occurred on 05/29/04 at approximately 10:30p.m. Description of Incident states 'upon making rounds, staff heard loud noises, upon arriving to the place where the resident was, the staff member was yelling and grabbing soda from resident and shoving resident . Bruises notes to left upper chest and shoulder area.' This report indicates physician was notified at 10:40p.m. and family notified at 10:55p .m. Description of incident does not indicate who the staff member. Report states a complete assessment was done head to toe on R19 and monitor for 72 hours.
E18 was interviewed on 09/13/04 at 11:15a.m. and stated she worked the evening of 05/29/04 to catch up on some work. She went to the third

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floor and stated she overheard staff talking about an incident with staff and a resident. E18 stated she completed the incident report on 05/29/04 and assessed R19, finding bruises on chest and shoulder and completing vital signs, calling R19's physician and family. E18 stated she spoke to E 19 and he stated that R19 and him basically had a minor shouting match about R19 taking a pop. After some discussion E18 stated she completed the incident report on 06/01/04 not 05/29/04. She then stated the physical assessment was actually completed on 06/01/04 including the vital signs. E18 did state she called the physician and family the evening of 05/29/04. E18 also stated that she spoke to E19 who said everything was covered and that he would complete an incident report regarding the altercation with R19. On 09/ 13/04 it was confirmed with E16, Director of Human Resources, that E18 was not on duty the evening of 05/29/04 and was not in the building that evening.

On 09/13/04 at 10:45a.m. E1 was interviewed regarding this alleged abuse and questioned why E19 continued to work after the alleged abuse. E 1 stated he learned of this incident the morning of 06/01/04 from an anonymous note he found under his door that morning. An investigation was initiated when he became aware of this incident.

On 09/13/04 at 10:50a.m. E3 was interviewed regarding this alleged abuse and questioned why E19 continued to work after alleged abuse. E3 stated she learned of this incident the morning of 06/01/04 the same time E1 learned of incident. During interview E3 confirmed she worked the night shift after this incident and stated she was

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F9999	Continued From page 25 not told of this alleged abuse. E3 stated if staff witness any abuse of a resident they should report it to the charge nurse or supervisor. On 09/13/04 at 10:55a.m. E15 was interviewed regarding this alleged abuse. E15 stated on 06/ 01/04 at approximately 9:30a.m. she found statements under her office door from E22 and E 23 (CNA's) dated 05/30/04 stating what they witnessed the evening between R19 and E19. E 15 stated she called E19, E22 and E23 to the facility and went over the abuse policy and took a statement from E19. E19 wrote that he was passing medications and attempted to redirect resident to his room. R19 had taken a can of pop off medication cart and asked R19 to return the pop. R19 stated 'no' and E19 took the pop from the resident. E15 stated that during interview E 19 stated that things got out of control and that he layed hands on R19 and also stated things were stressful. E15 stated E22 and E23 said they saw E19 slam R19 around and he stopped when he saw them. E19 was suspended pending investigation. During this interview surveyor referred to E15's nurses note dated 06/01/04 at 5:25p.m. and asked why R19 was not assessed for any injuries until 5:25p.m. when she became aware of the alleged abuse at 9:30a.m. E15 responded she had to call the staff in to begin the investigation. E15 was also asked if she obtained statements of other staff (E12, E25, E26 & E27) on duty, on the third floor, at the time of the incident. E15 stated she did not obtain statements from any other staff .	F9999		