

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145867		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2005	
NAME OF PROVIDER OR SUPPLIER FAIRMONT CARE CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 5061 NORTH PULASKI ROAD CHICAGO, IL 60630			
(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 226	Continued From page 7 Monitoring Tool results will be reported in Quality Improvement Meeting. 8. In addition to notifying the Administrator or Supervisor verbally, an Administrator Hotline number is posted in the front office and each Nursing station for reporting any allegation of abuse.			F 226			
F9999	FINAL OBSERVATIONS LICENSING VIOLATIONS 300.610a) 300.690a)1) 300.3240a)b)d)e) 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 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician,			F9999			

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F9999	Continued From page 8 hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. 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) 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 perpetrator 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. (Section 3-611 of the Act) Based on interview and record review, the facility failed to implement written policies and procedures that prohibit the abuse of residents by:			F9999			

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F9999	Continued From page 9 1. Not initiating an immediate investigation when an allegation of staff (E4 CNA) to resident (R2) abuse was received; 2. Allowing the alleged perpetrator to continue to provide direct resident care after the allegation was received; 3. Allowing the alleged perpetrator to work her next scheduled shift in a direct care capacity; 4. Not informing the Administrator of an alleged abuse. Findings include: 1. R2 is a 99 year old with diagnoses that include unspecified debility, degenerative joint disease, atrial fibrillation and Alzheimer's dementia. R2's most recent full MDS (Minimum Data Set) dated 05/30/2005 was reviewed. R2's score for "Cognitive Skills for Daily Decision-Making" was a "2"...moderately impaired-decisions poor; cues/supervision required." The MDS also documents that R2 requires extensive, one person physical assist for ADLs (Activities of Daily Living). R2 was interviewed, with the assistance of Z1 to interpret for this Spanish speaking resident, on 08/23/2005 from 12:20 PM to 12:50 PM in her room. R2 began by stating "I'm in bad shape." R2 then preceded to inform the surveyors that she was in the bathroom, getting a shower at the time of the incident, a staff member grabbed her arm and she was hurt. R2 stated that she told the staff member "I'm hurting, I'm hurting" and that the staff member continued to pull her arm. R2 also			F9999			

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F9999	Continued From page 10 stated that the staff member grabbed her upper arm and face below the chin. Though R2 was unable to provide the name of the alleged perpetrator, R2 was able to provide a physical description. During the course of the interview and later that day, the surveyors noted bruising (reddish purple in color) to R2's left (anterior aspect: approximately 1 inch round, posterior aspect: approximately 2 inches long and approximately 2 inches wide) and right upper arms (approximately 1 inch round) as well as a dressing to the left hand. The fingers to R2's left hand were noted to be swollen and discolored purple. 2. E4 was interviewed, via telephone, on 08/24/2005 from 11:45 AM to 12:00 PM. E4 stated that she first noted bruising to R2's left upper arm while showering R2 on 08/20/2005 at approximately 5:50 PM. E4 stated that she reported the bruising to E2 (RN) at that time and that E2 "just looked at the bruises and shook her head." E4 stated that R2 was "ok" during the shower, however, after transporting R2 back to her room to finish drying and dressing the resident, R2 "started grabbing and waving her hands... swinging at me...I grabbed her left hand and held it down 'til I finished drying her. I might have grabbed her too hard, but it wasn't intentional." E4 stated that she noted a "skin tear" to R2's left hand after she was done putting on R2's pull up pants on R2 and that she told E2 about the skin tear.			F9999			

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F9999	Continued From page 11 3. E1 (V.P. Operations/Acting Administrator) was interviewed on 08/23/2005 from 2:20 PM to 2:35 PM in the Administrator's Office. E1 informed the surveyors that she was not notified of the incident until 08/22/2005 and that E4 was not suspended from duty until 08/22/2005 because E3 (DON) "thought the incident was not intentional." Review of E4's time card documents that E4 worked from 6:54 AM to 10:53 PM on 08/20/2005 and for 6:58 AM to 3:13 PM on 08/22/2005. 4. E3 (DON) was interviewed on 08/24/2005 via telephone from 10:30 AM to 11:55 AM. The following information was given to the surveyor by E3. E3 interviewed E4 who informed E3 that while changing R2, R2 was resisting care. R2 waved her hands towards E4 and E4 held R2's hand to prevent R2 from hurting E4. E4 then called E2 because R2 sustained an injury to the top left hand. E3 stated that an incident report was made out on 08/20/2005 at 6:15 PM and that she was notified of the incident on 08/21/2005. E3 stated that R2's family was upset. The police were notified by a family member of R2's. The police said that no abuse had occurred, that it was an accident. E3 stated that IDPH (Illinois Department of Public Health) was not notified because it was not an abuse. E3 stated that she discussed the incident on 08/22/2005 with E1 and was instructed by E1 to report the incident to IDPH. E4 was suspended 08/22/2005 at 2:00 PM. 5. Z4 was interviewed on 08/23/2005 from 12:00			F9999			

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F9999	Continued From page 12 PM to 12:15 PM. Z4 stated that a family member informed her that R2 had been hurt. Z4 stated that she arrived at the facility to find R2 in bed, in a fetal position, face white, not speaking. R2 upon seeing Z4 stated: "Honey, you're hear to save me." R2 pointed to E4 who was in R2's room and stated: "This one, this one beat me up ...look at my hand...Honey she showered me in cold water." Z4 stated that R2 told her that the incident happened in the shower room. Z4 stated that E4 informed her "it was an accident" and that the bruises to R2's arms "were there when I got here." In a subsequent telephone interview on 08/24/ 2005 at 3:00 PM, Z4 stated that she reported the incident (of alleged abuse) to E2 on 08/20/2005. " I told E2 come and see what happened to R2." Z 4 stated that while E2 was in the room she translated for E2 what R2 was saying..."Oh look what she did to my hand...she almost killed me... look at my hand...she gave me a cold shower." 6. Z2 was interviewed on 08/24/2005 from 1:00 PM to 1:10 PM via telephone. The following information was given to surveyor by Z2. He was informed by the facility that R2 sustained superficial excoriation (doesn't recall location on body), but that the facility didn't tell him how the excoriation was sustained. Z2 has not seen the excoriation because he only goes to the facility once a month. Z2 described R2 as mostly bed ridden, without behaviors (resident might say leave me alone), doesn't strike out, doesn't verbalize a lot, has dementia.			F9999			

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F9999	Continued From page 13 7. Review of the facility's "Preliminary 24-Hour Incident Investigation Report" and "Final Incident Investigation Report" documents the allegation of alleged abuse was received on 08/20/2005 at 6: 10 PM. Per review of the Transmission Verification Report, the facility faxed the preliminary report to the Illinois Department of Public Health on 08/22/2005 at 3: 26 PM. 8. The facility's "Policy and Procedure for Investigating and Preventing Incidents of Resident Abuse" was reviewed. The policy states : -Any employee or agent who becomes aware of any allegation of abuse or neglect will report it immediately to the Administrator/Supervisor or Charge Nurse. The Administrator will be notified and initiate the investigation process. -Within 24 hours, after the report of alleged abuse or neglect is received, the Administrator must report the allegation to the following: ...The Illinois Department of Public Health. -For the protection of all residents during the investigation process, the staff member who is suspected of the abuse will be removed from direct resident contact until the investigation is completed.			F9999			