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S 000	Initial Comments Annual Licensure and Certification Complaint investigations 1696985/IL90346 (Federal Oversight of State Survey) : F201 and F224 1696949/IL90305 : F201 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.620a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies 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. Section 300.620 Admission, Retention and Discharge Policies a) All involuntary discharges and transfers shall be in accordance with Sections 3-401 through 3-423 of the Act.	S 000	Attachment A Statement of Licensure Violations	

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HEALTH FACILITIES AND REGULATION
(210 ILCS 45/) Nursing Home Care Act

(210 ILCS 45/3-402) (from Ch. 111 1/2, par. 4153-402)
Sec. 3-402. Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under Section 3-408 and by a minimum written notice of 21 days, except in one of the following instances:
(a) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs.
(b) When the transfer or discharge is mandated by the physical safety of other residents, the facility staff, or facility visitors, as documented in the clinical record. The Department shall be notified prior to any such involuntary transfer or discharge. The Department shall immediately offer transfer, or discharge and relocation assistance to residents transferred or discharged under this subparagraph (b), and the Department may place relocation teams as provided in Section 3-419 of this Act.
(c) When an identified offender is within the provisional admission period defined in Section 1-120.3. If the Identified Offender Report and Recommendation prepared under Section 2-201.6 shows that the identified offender poses a serious threat or danger to the physical safety of other residents, the facility staff, or facility visitors in the admitting facility and the facility determines that it is unable to provide a safe environment for the other residents, the facility staff, or facility visitors, the facility shall transfer or discharge the identified offender within 3 days after its receipt of the Identified Offender Report

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S 000	Continued From page 2 and Recommendation. (Source: P.A. 96-1372, eff. 7-29-10.) (210 ILCS 45/3-403) (from Ch. 111 1/2, par. 4153-403) Sec. 3-403. The notice required by Section 3-402 shall be on a form prescribed by the Department and shall contain all of the following: (a) The stated reason for the proposed transfer or discharge; (b) The effective date of the proposed transfer or discharge; (c) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below."; (d) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (e) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Source: P.A. 81-1349.)	S 000		

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S 000	Continued From page 3 (210 ILCS 45/3-408) (from Ch. 111 1/2, par. 4153-408) Sec. 3-408. The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Source: P.A. 81-223.) 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S 000		
S9999	Final Observations	S9999		

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S9999	Continued From page 4 These regulations are not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident was free from mistreatment, failed to allow resident (R23) remain in the facility after returning late from being out on pass and failed to follow their policies on Outside Pass Policy and Against Medical Advice (AMA) for 1 (R23) of 2 closed records reviewed for leaving the facility against medical advice (AMA) in the sample of 24 residents. This failure resulted in R23 becoming very irate along with verbal agitation when confronted by staff after returning late from an outside appointment and still requiring medical attention to 2nd degree leg burn and severe foot infection. The findings include: R23, a 59 year old, non-ambulatory male was admitted to the facility on 11/17/16 and re-admitted on 11/23/16 with diagnoses that include Major Depression, Epilepsy, Diabetes Mellitus II, Acute Osteomyelitis, 5th toe amputation and obesity per the initial Minimum Data Set (MDS) dated 11/24/16. R23's brief interview mental status (BIMS) is a "15" which indicates he is oriented times three (person, place and time.) The MDS documents R23 exhibits verbal behavior one to three times a week and rejects care 4 to 6 times a week. R23's care plan dated 11/24/16 documents his problematic areas to be exhibiting attention-seeking behaviors, exhibiting manipulative behavior at times, such as, giving	S9999		

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contradictory information on his history and therapy and hoarding of food. R23 exhibits intermittent episodes of verbal outburst and has surgical wound to his right 5th toe which was amputated as a result from Osteomyelitis of the right foot. The care plan addresses R23 receiving anti-psychotic medications for his diagnosis of Major Depression with psychotic features.

On 12/15/16 at 10:35 AM via phone conversation with Z3 (outside advocate), Z3 stated R23 was 45 minutes late in returning to the facility on 12/5/16. R23 had a 4 hour pass to come see Z3. Z3 stated she received a phone call from E3 (director of nursing) and E6 (Social Service Director) around 2 PM on 12/5/16 requesting to schedule a meeting with R23 and ombudsman to discuss a behavioral contract. Later that same day, Z3 states she receives a phone call from R23 all upset saying the facility is throwing him out of the facility for being late from out on pass. Z3 request to talk to E1 (administrator) but E1 would not take call from R23's phone. Z3 stated she called the facility's phone line and eventually spoke to E1. Z3 stated that E1 stated R23 was leaving AMA per his choice. Z3 stated that she understood that R23 is being discharged due to returning late to the facility and was the facility sending him to another facility. Z3 stated that E1 stated that R23 was leaving on his own accord and it was not considered a discharge but an AMA. Z3 stated when she had concluded her conversation with E1, she was told that R23 had left the facility. Z3 stated R23 is homeless and has no identification cards or medical card. Z3 stated that R23 left 2 to 3 voice messages about being very distraught, scared, not knowing what was going to happened to him or where to go and it being very cold outside. Z3 stated that R23 was not happy at this nursing home but was trying to adjust.

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Z3 stated R23 went to the facility due to an infection in his foot after amputation of his 5th toe. Z3 stated R23 was still receiving antibiotic treatment and dressing changes to his foot.

On 12/15/16 at 12:45 PM, E6 (Social Service Director) stated R23 was admitted for a foot infection. E6 stated that R23 would exhibit verbal aggression in regards to his medical treatment and would voice veiled threats toward staff but no actual physical harm or threats. E6 stated he had a good relationship with R23. E6 stated that R23 just wanted to be heard and to vent. E6 stated R23 is alert and orient times 3 (person, place and time). E6 stated R23 left the facility for a personal matter and was gone over 4 hours. E6 does not recall the exact time R23 returned. E6 stated R23 did speak to E6, E1(administrator) and the E19 (receptionist) about permission to leave facility prior to leaving the facility. E6 stated that the facility was planning on meeting with R23 and the ombudsman to develop a behavior contract regards to the 4 hour pass privilege and his foot infection. E6 stated R23 returned to the facility and became verbally aggressive toward E1, E3 and E6 when R23 was questioned about his whereabouts. E6 stated that R23 was exhibiting his base-line behavior of using vulgar language and was not re-directable as E1 and E3 explained the pass privilege. E6 stated he left the room 5 to 6 minutes into the conversation and left R23, E1 and E3 in the room.

On 12/15/16 at 1:07 PM, E1 (administrator) stated that E6 informed E1 and E3 that R23 was back in the facility and to come to E6's office. E1 stated that as E6 was explaining the 4 hour pass privilege R23 starts screaming, he is an adult, this is not a jail, I am only here for rehab and awaiting

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to get his car back. E1 stated that R23 was allowed to vent and then E1 decided that the conversation was going nowhere because R23 saying he does not want to be here, the place is terrible, and he is on his way. E1 stated herself and E3 left conference room for something and R23 ends up in the lobby at the front desk. E1 states that R23 is making calls on a cell phone in the lobby and tries to hand the cell phone to E1 who says she does not take calls from resident's cell phone for whoever it is to call the facility's phone number. E1 stated that a call from Z3 comes to the facility and she takes it. E1 stated that Z3 asks why she did not take the call from R23, E1 stated that she only takes calls on the facility line. E1 stated she informed Z3 that she can not discuss R23 because he has made the decision to leave and is no longer a resident here at the facility.

On 12/15/16 at 1:07 PM, E1 (administrator) stated that the meaning of being AMA is not returning on time from pass, not returning at all and/or family member taking resident out of facility without proper discharge plans in place. E1 stated R23 is alert and orient times three and left the facility on 12/5/16 at 10 AM and returned sometime after 4 PM, not sure of the exact time. E1 stated she could not recall if R23 ever violated the PASS privilege before this time but believes there was one time when he returned 15 minutes late pass the curfew time. E1 stated that Z2, the nurse practitioner was here waiting to see his foot infection but R23 was not here. E1 stated she was aware of R23's visit into the community to see Z3.

E1 stated when R23 returned to the facility, it was herself, E3 and E6 that explained the 4 hour pass is due to his foot being infected and requiring

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medical treatment. E1 stated that earlier in the day, E6 called Z3 to see where R23 was because Z2 (Nurse Practitioner) was in the facility and wanted to see him. E1 stated that E6 was told not to have R23 come to office because Z3 has no time to see R23. E1 stated that E6 was informed at that time that Z3 had not seen R23 yet.

E1 stated that E6 informed E1 and E3 that R23 was back in the facility and to come to E6's office. E1 stated that as E6 was explaining the 4 hour pass privilege R23 starts screaming, he is an adult, this is not a jail, I am only here for rehab and awaiting to get his car back. E1 stated that R23 was allowed to vent and then E1 decided that the conversation was going nowhere because R23 saying he does not want to be here, the place is terrible, and he is on his way. E1 stated herself and E3 left conference room for something and R23 ends up in the lobby at the front desk. E1 states that R23 is making calls on a cell phone in the lobby and tries to hand the cell phone to E1 who says she does not take calls from resident's cell phone for whoever it is to call the facility's phone number. E1 stated that a call from Z3 comes to the facility and she takes it. E1 stated that Z3 asks why she did not take the call from R23, E1 stated that she only takes calls on the facility line. E1 stated she informed Z3 that she cannot discuss R23 because he has made the decision to leave and is no longer a resident here at the facility.

E1 stated that R23's belongings are still here and another nursing home called to say they want to pick up R23's belongings.

After E1 read the facility's PASS Policy, E1 agreed that R23 did not violate the Pass policy. The policy documents that if not returning on time

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from out on pass, the pass privilege would be revoked. E1's response to this is that R23 never allowed this to come up due to his vulgar language and R23 saying he does not want to stay here.

On 12/15/16 at 2:05 PM, E3 (director of nursing) stated that R23 was difficult to please and he expressed that he did not want to be in a nursing home. E3 stated that R23 had some legal problems in the community he needed to take care of and wanted to come and go. E3 stated that R23 left the facility on 12/5/16 to go to court. The pass was for 4 hours only. E3 stated she does not know how long R23 was out but he returned at 3:15 PM and signed in at the receptionist's desk.

E3 stated that Z3 called earlier in the day around 2 PM and stated she was busy and not to send R23 down to her office. E3 stated she believes that R23 never saw Z3. E3 stated that Z2 (nurse practitioner) was here to exam R23's foot and he was not here. E3 stated that Z2 stated R23 is out against medical advise in regards to his foot and is out of facility for over 4 hours. E3 stated Z2 was still in the facility when R23 came back. E3 stated that Z2 wrote an order for AMA due to the resident saying he does not want to be here. E3 stated she is not sure if Z2 ever looked at R23's foot.

E3 stated that when R23 returned to the facility, it was R23, E1, E6 and possibly E19 (receptionist) who were all in the lobby. E3 stated she saw this from a distance and the discussion started to escalate louder with a lot of swearing and yelling. E3 stated she left the area and went to do her job.

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E3 stated that R23 was in the lobby making phone calls on a cell phone prior to leaving AMA. E3 stated she believes someone picked him up at facility.

On 12/16/16 at 9:47 AM, E19 (receptionist) stated she recalls R23 leaving the facility on 12/5/16 at 9:30 AM or 10 AM. E19 stated not to be sure when R23 returned because she did not see him return. E19 stated she recalls E6 and E20 (staffing coordinator) asking R23 if he needed transportation and to wait because of the cold weather prior to R23 leaving the facility. E19 stated she works 8 AM to 4:30 PM Monday through Friday.

On 12/16/16 at 10:48 AM via phone conversation, Z2 (nurse practitioner) stated that she was informed by E3 that R23 was not in the facility. Z2 stated she wrote the order for AMA because R23 was not in the facility and was told by E3 that there is no order for R23 to be out of the facility. Z2 stated R23 was okay with her and exhibited a calm demeanor. Z2 stated that when she would want to see his foot, he would request later and Z2 would came back later and R23 would allow his foot to be examined. Z2 stated she could not remember if she ever saw R23 on 12/5/16 when she wrote the AMA order.

On 12/20/16 at 7:45 AM via phone conversation, R23 stated he asked permission from E6 if he could go to see Z3 (an outside advocate). R23 stated E6 asked E1 if it was okay and it was okay. R23 stated he took the bus ride to Z3's office, waited and met with Z3, then returned back to the facility and was 30 to 35 minutes late (past the 4 hours) on getting back to the facility. R23 stated he was in the lobby with E1, E3, E6 and E19 when he was confronted with being late from his

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4 hour pass. R23 states the conversation gets louder with everyone yelling in the lobby when E3 states that the conversation needs to be moved down to the conference room. All 4 of them (R23, E1, E3, E6) go to a conference room where the discussion goes on for 30 minutes. R23 stated that he believes E1 had made up her mind about R23 being thrown out of the facility. R23 states that E1 tells a staff person to pack up all R23's belongings and tells R23 to wait in the lobby. R23's belongings consists of 3 boxes which are put in the lobby. R23 stated he used another resident's phone to call Z3 but E1 would not speak to Z3 on the cell phone. R23 stated he got money from another resident to take the bus to the hospital. R23 stated he has yet to pick up his belongings from this facility. R23 added that he believes this all stems from the fact he received a severe burn to his thigh when a CNA gave him hot water per R23's request. R23 added that he did not want to be in the nursing home but was trying to make the best of it.

Z2's progress note dated 11/23/16 documents R23 is being treated for Osteomyelitis on the right foot toe status post amputation. R23 was being treated with vancomycin and levofloxacin (both antibiotics) then it changed to another antibiotic, Bactrim until 1/4/17. R23 was complaining to increase pain to his right foot.

The nursing progress note dated 12/5/16 at 3:45 PM documents Z2 (nurse practitioner) was still in the facility when R23 was discharged from the facility and was aware of the AMA status. There was no documentation to support that R23's foot was examined.

There is another nursing progress note dated 12/5/16 that documents R23 reporting to E15

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(wound nurse) that he had a skin injury. E15 documents that upon inspection there is a 2nd degree burn to his left front thigh, base 10% of pinkish tissue and 80% of hard yellowish slough, moderate amount of serous exudates, odorless, margins flat equal intact, affected area measuring 7.2 by 6.2 centimeters. Spoke with physician with orders to cleanse the wound with normal saline, apply silverdene cream sparingly and cover with dry dressing and secure with tape daily per the 12/5/16 physician's order.

R23's clinical record lacks documentation of R23 ever violating any other rules in the facility, being late on return from pass, being physically out of control or threats to do physical harm to anyone and not being able to re-direct. The 12/5/16 incident is the only documented time that R23 was late from being out on pass. There is no documentation to support the rationale for R23 being turned out of the facility by E1 on 12/5/16.

The facility's sign in/out sheet was at the front desk. On it, was R23's signature dated 12/5/16 signed out at 10:15 AM and signed in at 3 PM upon return to facility which was confirmed by R19. When E19 was questioned about returned time of 3 PM for R23, E19 stated that she tries to check the sheet for time accuracies but she does not always catch it. E19 stated she did sign the AMA sheet for R23 and says she signed it before she left that day.

The facility's policy labeled "Policy and Procedures for Against Medical Advise" documents that 2 staff members are to witness the AMA form when the resident refuses to sign the AMA form. R23's AMA form was signed by E6 and E19. E19 stated in her interview that she did not see R23 return back to the facility but signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006795	A. BUILDING: _____ B. WING _____	C 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT OAK PARK R & N CTR	625 NORTH HARLEM OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 13 the AMA form upon completion of work schedule. E19 did not witness R23 refuse to sign the form. The facility's policy labeled "Outside Pass Policy" documents that a resident returning to the facility in a timely manner and as agreed upon with the facility staff. Failure to return by the agreed upon time will be grounds for revocation of privilege unless the resident has contacted the facility and made appropriate arrangements with administrative representative. The facility's policy labeled Abuse Prevention Program Facility Policy documents the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property, corporal punishment and involuntary seclusion. The facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. This policy was not followed. (B)	S9999		