

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ILL6008320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/03/2017
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NAME OF PROVIDER OR SUPPLIER MADO HEALTHCARE - DOUGLAS PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 SOUTH ALBANY CHICAGO, IL 60623
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S 000	Initial Comments	S 000		
	Complaint 1782401/IL93463-no findings. Complaint 1782452/IL93539- Licensure Findings			
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.625b) 300.625f)4) 300.625j) 300.625m) 300.1210a) 300.1210b) 300.1210d)6) 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 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.</p> <p>Section 300.625 Identified Offenders</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

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

TITLE

(X6) DATE

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S9999	Continued From page 1 b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. f) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements: 4) If the identified offender is on probation, parole, or mandatory supervised release, the facility shall contact the resident's probation or parole officer, acknowledge the terms of release, update contact information with the probation or parole office, and maintain updated contact information in the resident's record. The record must also include the resident's criminal history record. j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. m) The facility's reliance on the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act shall not relieve or indemnify in any manner the facility's liability or responsibility with regard to the identified offender or other facility residents. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		
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S9999	Continued From page 2	S9999		
	<p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</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 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</p>			

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S9999	<p>Continued From page 3</p> <p>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>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> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to implement a interventions to address a history of criminal assault for one resident (R2) and failed to intervene and protect R1 from physical assault by R2. R1 and R2 are two of four residents reviewed for abuse in the sample of five. These failures resulted in R2 becoming enraged, throwing R1 from a chair, hitting R1 with the chair and repeatedly stomping on R1's head with his foot as staff stood by. R1 was admitted to the hospital with a head injury and subsequently died of complications from cerebral (brain) injuries.</p>	S9999		
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Findings include:

The facility's Abuse Prevention Program Facility Procedures, dated 1999, documents that "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and had attempted to establish a resident sensitive and resident secure environment." This same form documents "As a part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict."

The facility's Client Background Checks and Identified Offender Policy, dated 1/8/15, documents that the facility is responsible for taking necessary steps to ensure the safety of clients while the results of a background check or other Identified Offender report and recommendations are pending. This same form documents that the facility must specify if a Reportable Incident involves an Identified Offender. The Incident Report must specify if the incident involves substance abuse, aggressive behavior, inappropriate sexual behavior or any other behavior or activity that would be reasonable likely to cause harm to the Identified Offender or others.

R2's pre-admit referral packet, dated 5/17/16, documents a diagnosis of Major Depression Disorder, recurrent. This same form documents that R2 states that R2 has had anger issues since R2 was a child. R2 stated that R2 was involved in an aggravated battery and received a two year

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S9999	<p>Continued From page 5</p> <p>sentence. During that time while R2 was incarcerated, R2 got into frequent fights and altercations with both the prison guards and other prisoners, thus extending R2's incarceration from two years to eight years, which R2 served completely. This same form documents that R2 states that "I feel like I have a split personality" and that "R2 is at risk of harm to self or others as evidenced by (R2) reporting thoughts to harm self and others with a plan to either jump on the El tracks (city railway transit system) and kill himself or get access to a gun and kill somebody."</p> <p>R2's Progress Notes, dated 6/1/16, documents that R2, upon admission, was admitted to the facility's Crisis Stabilization Unit from a local hospital where R2 was treated for suicidal/homicidal ideation. Clinical record also documents that R2 was in a motor vehicle accident prior to hospitalization and received a fractured wrist for which R2 had a cast applied.</p> <p>R2's Care Plan, dated 6/6/16, does not have any documentation about R2 being a possible identified offender, history of aggravated assault with battery, and does not include any interventions related to aggressive or assaultive behavior. R2's clinical record did not have an interim care plan.</p> <p>R2's Social Service Notes and Nurses Notes, 6/1/16 through 6/7/16, contained no documentation of R2's probation officer being notified of admission and no history of aggressive behavior.</p> <p>The facility's "Final Incident Investigation, dated 6/7/16, documents that R2 was told that R2's appointment was changed (to another date). R2 threw R2's cell phone against the wall and walked</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>to the TV room and flipped R1 out of the chair. R2 threw the chair at R1 and continued to hit R1 while R1 was on the floor. This same form documents that R2 was on probation and was sent to jail for battery of a senior.</p> <p>R2's Nurses Notes, dated 6/7/16 at 10:25am, documents that R2 approached the third floor nurses station to inquire about a doctor appointment. E6's, Certified Nursing Assistant, signed statement, dated 6/7/16, documents that R2 was told that R2's doctor appointment was changed to a different day, and that R2 jumped out of R2's chair, threw R2's phone against the wall, then stated "I'm going to set this b...h up, call the police." This same document states that E6 watched the monitor (after R2 left the nurses station), and saw R2 throw a chair, and saw R2 stomping on R1's head.</p> <p>On 4/26/17 at 1:30pm, E4, LPN (Licensed Practical Nurse), stated that R2 had come to the nurses station because he stated he had an appointment to have his cast checked that day. When R2's found out the appointment had been changed to a different day, R2 threw his phone against the wall then walked to the television room, and E4 heard shouting. E4 called security which was located on the same floor. E4 went to the television room which is approximately 50 feet from the nurses station and saw R2 beating on R1. E4 did not try to remove R2 from R1 until security came from the same floor and the second floor and broke up the incident.</p> <p>On 4/26/17 at 12:20pm, E3, Director Of Nursing, verified that E3's office is on the third floor. E3 stated that E3 heard yelling coming from the television room. E3 stated that E3 saw R2 beating R1 with a chair. E3 stated that E3, yelled</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>"STOP, STOP, STOP," but R2 did not stop, until security came and apprehended R2. E3 stated that R1 was bleeding from R1's head, R1 would open R1's eyes, but would not respond verbally. E3 stated she did not intervene or try to remove R2 from R1. E3 stated that R1 was not moved until the ambulance came, and was transported to the hospital. E3 stated that R2 was taken away by the police. E3 verified that a code gray to alert security was called. Two security guards responded, one located on the same floor and one who came from the second floor.</p> <p>On 4/27/17 at 1:20pm, E7, Security Officer, stated that a code was called for the television room on the third floor where he was located in the (facility) crisis stabilization unit. E7 stated that when E7 entered the television area R2 was stomping on R1's head with R2's foot. R2 attempted to leave the facility, but was redirected by security and placed on one on one. E7 stated that R2 was taken to the crisis stabilization unit, until the police arrived. R2 was transferred to a local hospital for a psychiatric evaluation. R2 was admitted to the hospital with a diagnosis of aggressive behavior.</p> <p>On 4/27/17 at 10:00am E2, Assistant Administrator, verified that R2 was on probation and that there was no documentation of R2's probation officer being notified of R2's admission to the facility. E2 also verified that R2's criminal history background check was not back at the time of R1 and R2's incident. E2 verified that R2 did not have an interim care plan initiated, and the only care plan that could be found for R2 was dated 6/6/16 and contained no information regarding R2's history of assault. E2 also stated that R1 was immediately transferred to the hospital and was admitted the intensive care unit</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>and that at a later date R1 was transferred to another hospital and placed on life support and passed away.</p> <p>A death certificate for R1 documents the date of death for R1 as 04/18/17 and the following as causes of death: 1. Complications of Remote Cerebral Injuries. 2. Blunt Force Trauma to the Head. This same form documents under "Describe how injury occurred" as "Blunt force trauma to the head inflicted by others" and was certified by the Medical Examiner on 04/25/17.</p> <p>On 04/27/17 at 11am Z4 (Detective with the County Police) stated that R2 remains in jail.</p> <p>(AA)</p>	S9999		
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