

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ILL6001994</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/27/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COLUMBUS MANOR RES CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5107 21 WEST JACKSON BOULEVARD CHICAGO, IL 60644</b>
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S 000	Initial Comments  Incident Report Investigation to Incident of 6/7/17. IL 95636.	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.1210d)6). 300.3300d)1)e)1)2)3)4)5)g)k).  Section 300.1210 General Requirements for Nursing and Personal Care.  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:  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.  These Regulations were not met as evidenced by:  Based on interview and record review the facility failed to provide supervision for a resident on a safe smoking program, to prevent a mattress fire, for one resident (R1) of three reviewed for safety in a sample of six.  Findings include:  The facility's Safe Smoking Program Participant	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

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

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>Procedures, updated 6/1/17, documents that, residents in the Safe Smoking Program must turn over all lighters, cigarettes, and other smoking related items to staff (which will be distributed accordingly during monitored smoke times. This same form documents that cigars are passed out every two hours in the courtyard during monitored times. Staff will announce during those times and participants are to report promptly in order to receive their cigars. Any unfinished cigars must be discarded upon entering back into the building (no attempts to save cigars for later will be allowed).</p> <p>The facility's Smoking Management Group policy, undated, documents "Residents are staff supervised, and will be distributed two cigarettes (one at a time) to smoke every two hours, from 7:00am to 10:00pm in the designated area."</p> <p>R1's Care Plan, dated 4/25/17, documents that R1 is to attend a safe smoking group weekly, but refuses.</p> <p>The facility's Preliminary Incident Report Form, dated 6/7/17, documents "At around 09:18am, Resident (R1) accidentally ignited the bottom of his fitted sheet and lower end of his mattress while smoking in bed. The security (E3) smelled smoke during his round in building 21 and proceeded to investigate. (R1) was escorted out of his room by the security officer (E3), who then pulled the fire alarm and proceeded to extinguish the small fire with fire extinguisher. 911 was also notified."</p> <p>On 7/26/17 at 12:40pm, E3, Security Director, stated that E3 entered R1's room, there was a lot of smoke. E3 stated that E3 escorted R1 out of the room, pulled the fire alarm, returned with a</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>fire extinguisher and put out the fire. E3 stated that E3 also broke out the window to rid some of the smoke. E3 also stated that the whole building was evacuated, until the fire department gave the all clear. E3 stated that the fire was at the foot of R1's bed.</p> <p>On 7/27/17 at 10:00am, E6, Security Guard, stated that Residents on the Safe Smoking Program receive cigarettes every two hours, during the day. E6 stated that Security goes into the court yard and passes them out. E6 also stated that a light is given if needed. E6 stated that E6 did not go to the court yard for R1's morning cigarette on the day the fire happened. E6 stated that E6 does not know how R1 got a cigarette or lighter.</p> <p>On 7/27/17 at 9:50am, E5, PRSC, (Psych/Rehab Service Coordinator), stated that security passes out the cigarettes to the residents on the Smoking Program. E5 stated that security is not in the court yard, but monitor the residents through the video cameras. E5 stated that E5 is not aware of how R1 got a cigarette or lighter.</p> <p>On 7/27/17 at 12:00pm, E4, Social Service Director, verified that CNA, (Certified Nursing Assistants) go on rounds every hour. E4 also stated that Security does rounds opposite of the CNA's. If the CNA goes on rounds on the hour, Security goes on rounds on the half hour.</p> <p>Section 300.3300 Transfer or Discharge</p> <p>d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>days, except in one of the following instances:</p> <p>1) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs; (Section 3-402(a) of the Act)</p> <p>e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:</p> <p>1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)</p> <p>2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)</p> <p>3) A statement in not less than 12-point type, which reads:</p> <p>"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</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>questions, call the Department of Public Health at the telephone number listed below."; (Section 3-403(c) of the Act)</p> <p>4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)</p> <p>5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act)</p> <p>g) A copy of the notice required by subsection (d) (1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, the resident's representative, and, if the resident's care is paid for in whole or part through Title XIX, to the Department of Healthcare and Family Services. (Section 3-405 of the Act)</p> <p>k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 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 provide a 21 day notice, the appeal process, provide counseling, obtain a Physician's order prior to an involuntary discharge, and notify the State Agency, for three of three (R1, R4 and R5) residents reviewed for involuntary discharge in a sample of six.</p> <p>Findings include:</p> <p>The facility's Policy on Involuntary Transfer (IVD),</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>undated, documents "In the event that emergency involuntary transfer/discharge becomes necessary the facility is responsible for: Notify the appropriate physician (attending or psychiatrist) to discuss the appropriate immediate plan for the resident to protect the resident's safety and the health and safety of other individuals. The physician should order emergency transfer and enter a note explaining the situation (at the appropriate time). Carry out physician orders regarding emergency transfer. A telephone order is sufficient. Document the reason (s) for emergency transfer in the medical resident's medical record. Complete a transfer form and the appropriate State of Illinois Petition for Involuntary/Judicial Admission form."</p> <p>R1's Progress Notes, dated 6/7/17, documents that R1 was discharged from the facility, to the hospital for an evaluation.</p> <p>R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, documents that R1 was involuntarily discharged on 6/7/17. This same form does not have the reason for R1's involuntary discharge, or where R1 was discharged to documented. This form does not have any documentation that R1 was notified of the appeal process or the hearing process. R1 was not given a 21 day notice, prior to being discharged. There is no documentation that a stamped envelope was given for the appeal process.</p> <p>The facility's Preliminary Incident Report Form, dated 6/7/17, documents "At around 09:18am, Resident (R1) accidentally ignited the bottom of his fitted sheet and lower end of his mattress while smoking in bed. The security (E3) smelled smoke during his round in building 21 and</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>proceeded to investigate. (R1) was escorted out of his room by the security officer (E3), who then pulled the fire alarm and proceeded to extinguish the small fire with fire extinguisher. 911 was also notified."</p> <p>R1's Progress Notes do not have any smoking violations documented from 1/16/17 through 4/6/17. There is no documentation that R1 received any counseling prior to being involuntarily discharged. There is no documentation that the State Agencies were notified of R1's involuntary discharge.</p> <p>R1's Physician Order Sheet, dated 6/1/17 through 6/30/17, does not document a discharge order, or the reason an involuntary discharge was necessary.</p> <p>R4's Notice of Involuntary Transfer or Discharge Form, dated 1/12/17, documents that R2 was involuntarily discharge, with no destination noted. Page three of this form is blank, there is no documentation that R4 was notified of the hearing process, or given a stamped enveloped with the State Agencies address. There is no documentation that the State Agencies were notified of R4's involuntary discharge. R4 was not given a 21 day notice, prior to discharge.</p> <p>R4's Physician Order Sheet, dated 1/1/17 through 1/31/17, does not document a discharge order, or a reason for the involuntary discharge.</p> <p>R4's Social Service Note, dated 1/12/17, documents that R4 was given immediate discharge and petition. There is no documentation of any counseling services prior to R4's discharge.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>R5's Progress Notes, dated 4/20/17, documents that R5 was sent to the emergency room, and an immediate involuntary discharge was given. There is no Physician note concerning the reason for R5's involuntary discharge.</p> <p>There is no documentation, at all, that R5 was given the Notice of Involuntary Transfer or Discharge paperwork. There is no documentation that R5 was notified of the involuntary discharge appeal process, or a stamped envelope with the address of the state agency. There is no documentation that the State Agencies were notified of R5's involuntary discharge.</p> <p>On 7/26/17 at 11:45am, E2, Director of Nursing, verified that the Social Service department issues the involuntary discharges. E2 stated that the State Agencies are not notified of the involuntary discharges. E2 stated that R1 was given an involuntary discharge because smoking is not allowed in rooms.</p> <p>On 7/27/17 at 9:25am, E4, Social Service Director, verified that the State Agencies were not notified of any of the facility's involuntary discharges. E4 stated that R1 and R5 did not have a Physicians order for the involuntary discharge. E4 verified that R5 did not receive any of the involuntary discharge paperwork. E4 also verified that there is not a physician note as to why R1, R4 and R5 were involuntarily discharged. E4 stated that R1 did not have any prior smoking violations. E4 stated that the appeal process was not explained to R1, R4, or R5. E4 also stated that the involuntary discharge paperwork given to R1, R4 and R5 was incomplete.</p> <p>On 7/27/17 at 9:50am, E5, Psych/Rehab Service Coordinator, stated that E5 fills out the paperwork</p>	S9999		

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S9999	Continued From page 8  for involuntary discharges, then it is given to E2. E5 stated that E5 does not notify the State Agencies concerning involuntary discharges.  (B)	S9999		
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