

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007918	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/26/2021
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NAME OF PROVIDER OR SUPPLIER LANDMARK OF RICHTON PARK REHAB & NSI	STREET ADDRESS, CITY, STATE, ZIP CODE 22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471
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S 000	Initial Comments Facility Reported Investigation (FRI) of 3/16/21 IL131961	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)2) 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 300.1210 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	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	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</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>These Requirements were not met evidenced by:</p> <p>Based on interview, and record review, the facility failed to follow their Abuse Prevention Policy, and failed to monitor and implement appropriate interventions to keep a resident safe from physical abuse for 1 of 3 residents (R1) reviewed for abuse. This failure resulted in R1 being hit by</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R2 during aa verbal altercation causing the resident to fall and sustain a laceration to the left eyebrow.</p> <p>Findings Include:</p> <p>The Facesheet documents that R1 is a 59 - year old resident admitted to the facility with a diagnosis of Schizoaffective Disorder and R2 is a 28 year old resident admitted with Schizoaffective Disorder, Bipolar Disorder, and Psychosis.</p> <p>Incident Report dated 3/16/21 documents that R1 was in a verbal altercation with R2 and was hit by the resident causing R1 to fall. R1 was observed on the floor with a laceration to the eyebrow. R1 was sent out to the hospital for evaluation and required four sutures. R2 was placed on 1:1 monitoring and was hospitalized for a psychiatric evaluation.</p> <p>Nurse's Notes dated 3/16/21 documents that staff was alerted to the resident's room by a loud sound. R1 was observed on the floor bleeding from the forehead. R1 tried to get up and walk against staff's orders and was observed to be weak, and unsteady. R1 was assisted to the floor, pressure applied to the resident's forehead until the paramedics arrived.</p> <p>Social Service Notes dated 3/17/21 documents that R1 admitted to staff that there was an incident of aggression between R1 and R2. The residents' were separated and R1 was relocated to a different room.</p> <p>R1's care plan documents that the resident is at an increased risk for abuse related to a history of behaviors. The Brief Interview for Mental Status (BIMS) Score dated 1/20/21 documents that R1</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>scored 13 out of 15 and is cognitively intact. R1's Minimum Data Set (MDS) dated 1/20/21 documents that the resident has an unsteady gait and ambulates with a cane or wheelchair.</p> <p>Nurse's Notes dated 3/2/21 documents that R2 had an argument with a peer while standing in line and hit the resident without warning. Staff intervened and separated the residents. R2's care plan documents that the resident has conflict with staff and other residents' related to open criticism and unprovoked expressions of anger.</p> <p>On 3/23/21 at 2:55pm R1 was observed lying in bed with a laceration to the left eyebrow. R1 stated "I got this scar on my head because R2 hit me and I fell and hit my head on the floor. R2 has never hit me before. I feel safe in the facility now since the resident is gone and they moved my room."</p> <p>On 3/23/21 at 12:05pm V2 (Social Service) stated "After the incident I interviewed R1 and the resident was reluctant to say what happened. R1 did admit to being hit by R2 after having a disagreement while being in the resident's room. R1 fell and there was a laceration over the eye and the resident was sent to the hospital. The residents' were separated and R2 was counseled and placed on 1:1 monitoring until the resident was transferred to the hospital for a psychiatric evaluation."</p> <p>The Abuse Prevention Policy documents that the facility will prohibit and prevent resident abuse, neglect, exploitation, mistreatment, misappropriation of resident property and a crime against a resident in the facility.</p>	S9999		

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