STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. BUILDING _____ B. WING _____	09/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD HEALTHCARE & REHAB.	**19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425**

(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 469	Continued From page 117 concerning the flies in the building at approximately 3:45pm. E15 stated that there are flies in the building because residents open windows on the side where the screens were not located. 2. Per record review, the facility outside extermination company only baited for rodents in the last six months and made no recommendations for flies. 3. House flies were observed during the orientation tour of August 14, 2006 with E3 (House Supervisor/patient care coordinator): D4, D2, D12, D8 and D1. -During the meal observation of August 15, 2006 in the main dining area flies were noted in the front area of the dining room and in the feeder section. -During observations of resident care on August 15, 2006 at 9:15am two house flies were noted in room D8. The flies were noted to buzz around and land on R2's head. -During the dining meal observation of August 17, 2006 in the main dining area files were noted around resident's food trays. Residents were observed swing at the flies.	F 469		
F9999	FINAL OBSERVATIONS Licensure Violation 300.1210a) 300.1210b)3) 300.1220b)2) 300.3240f)	F9999		

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F9999	Continued From page 118 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.1220 Supervision of Nursing Services 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. 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 119 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. These requirements are not met as evidenced by: Based on observation, record review and interviews the facility did not ensure each resident in the facility is adequately supervised and monitored to prevent resident to resident abuse and did not implement interventions to prevent inappropriate, aggressive and abusive behaviors of residents by failing to: - Protect residents in the facility from the abusive behaviors of R16. R16 is a cognitively impaired resident who exhibits physically aggressive behaviors toward other residents. - Protect R17 from being hit by R48, while R17 was on one to one supervision. -Investigate resident to resident abuse involving 8 residents (R11, R15, R16, R17, R52, R54, R55 and R56). -Investigate incidents of injury of unknown origin (R53). -Address residents initiating physically abusive behavior after any resident to resident altercations and implement interventions (R11, R16, R48 and R55). -Monitor and redirect a female resident who consistently entered a male resident's (R46)	F9999		

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F9999	Continued From page 120 room. The result of the facility's failure to adequately supervise and monitor residents throughout the facility and to implement interventions to supervise and redirect aggressive and abusive residents, led some residents to be fearful and believe they could not be protected from being harmed by R16 and R17. Findings include: 1. R16 is a 42 year old resident admitted to the facility on May 19, 2006 with the following diagnoses: Closed Head Injury, Cerebral Vascular Accident, Agitated Depression, Delusional Disorder and Hypertension. R16 was noted to have two incidents of striking other residents, one incident on July 16, 2006 and the other on July 31, 2006. Neither incident was investigated and the July 31, 2006 incident was not reported to Public Health as resident to resident abuse. R16 was also noted on July 26, 2006 with a discolored left eye and this incident was neither reported or investigated as abuse. During group and individual interviews, residents voiced fear of this resident (R16) and another resident (R17). Residents stated, "(R16) and (R17) need to be out of here." Residents stated that R16 hit other residents and was aggressive in the dining area. Residents stated the staff did not intervene. R16's behaviors given by residents included R16 hitting a resident while in the dining room and staff not able to stop it from happening. When the surveyor asked if staff was	F9999		

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F9999	Continued From page 121 told, the reply was, "How can they protect us, when he almost raped an aide." A resident also stated, R16 had attempted to assault a female staff member and a review of the incident reports indicated R16, "almost stripped one of the aides naked, hit one aide on the back and even hit me." These issues were treated by facility administration as "concerns" and were not investigated or treated as abuse. R16 was also noted per the incident report and nursing notes to "hit another resident" on the day program bus. The incident report and the nursing notes describe R16 as being agitated and this incident as "hitting." This incident was not investigated and E3 (house supervisor) alleged that it was an accident because she "saw it." Z6 (family member) and R15 stated during interview that R16 purposefully hit R15. Witnesses and or staff were not interviewed to determine the allegation. Z6 stated, "He hit her and she is afraid of him." R15 also indicated that she was afraid of R16. 2. R17 was admitted to the facility on July 16, 2006 with a history of known behavior problems. R17's diagnoses include Brain Injury, Seizure Disorder, Hypertension, Hepatis and Hypothyroidism. A review of the resident's medical record and MDS (Minimum Data Set) assessment of July 23, 2006 documented R17 showed physically and socially inappropriate behavior. The MDS also stated R17 resists care. During the survey, this resident was observed running out the side door of the B wing exit. This is not the usual entrance to the facility. Staff	F9999		

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F9999	Continued From page 122 responded to the door alarm and brought R17 back into the facility. In addition, R17 was observed in the dining room on August 15, 2006 in an adult chair with a tray table. R17 was sliding under the table in an attempt to escape the chair. Record review documented, R17 was noted to attempt to hit others on July 22, 2006 and on July 29, 2006 was noted to wander about the unit and staff were unable to redirect this resident. On July 21, 2006 the resident was noted to be agitated and was given medication for this. On August 10, 2006 the resident was noted to be throwing items and was again given medication. Residents and family members interviewed stated that they are "afraid" of R17. Per interview with E1, R17 should be on one to one monitoring for behavior and during the survey, E1 never gave surveyors the reason or specific behavior that R17 demonstrated to need 1 to 1 interventions. R17 was observed without 1:1 supervision on August 16, 2006. R17 was noted to be restrained in his adult chair with a tray table without staff present. R17 was sleeping. A review of the resident's plan of care and assessment indicates that there is no behavior plan or interventions to deal with R17's behavior. The nursing staff has not been trained in dealing with abnormal behavior. Social services has not provided services for R17 to aid in his adjustment to the facility. 3. On 8/15/2006, during a 9:00am medication pass, R17 was observed hitting E21 (female nurse aide). Later, R48 came to R17, while in the presence of staff, and hit R17. This incident happen while R17 was to receive one to one supervision from the facility staff. No staff	F9999		

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F9999	Continued From page 123 intervention was implemented to protect R17 from R48. 4. The surveyor on 8/15/2006 reviewed the facility's incident report book. The examples that follow demonstrate how the facility failed to protect residents and address residents with physically abusive behaviors. The following information was obtained and copied: -R52: 3/15/2006 at 11:15am, called to main dining room per staff, resident having altercation with another resident R11. Patient sustained swelling and small cut to upper right eye lid and bleeding from mouth no loss of teeth noted. Patient stated patient R11 called name using profanity. I got up to get him. Witness account of events, facts only: Noted resident on floor on top of peer. Peer kicking resident in face. This nurse (E23), et (and) staff members separated the two. Supervisor's investigation of event and interventions: Resident instructed and encouraged to notify staff when someone calls him a name. Follow-up implementation /disposition: None documented. No notification to the state agency indicated. R11: 3/15/2006 at 11:15am, called to main dining room per staff, resident having altercation with another resident R52. Staff observed it patient on floor kicking at R52. Patient separated immediately body check done. Witness account of events facts only: Noted resident on floor on top of him. Noted resident kicking peer in face. Both residents separated by this nurse, et staff.	F9999		

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F9999	Continued From page 124 Supervisor's investigation of event and interventions: encouraged not to use profanity when addressing peer and staff Follow-up implementation/ disposition: none documented. No notification to state agency was indicated. No intervention was noted to address R52's aggressive behavior -R54: 7/16/2006 at 2:30pm while in the hallway, resident was hit by one of our residents on the nose and he was bleeding in the hallway. No witness account of events documented. No supervisor's investigation of event and interventions documented. Follow-up implementation/ disposition: Put ice pack on the nose to stop bleeding, then send resident to emergency room. State agency notification was indicated. R16: 7/16/2006 at 2:00pm, R16 was very agitated and hit one of our residents (R54) on the nose, in the hallway. Also, resident (R16) "almost stripped one of the aides naked, hit one aide in the back, Even hit me also." No witness account of events documented. Supervisor's investigation of event and interventions : standing a little close to him to prevent other resident from passing close to him. Follow-up implementation/disposition: Medication given as needed. State agency notification was indicated. There was an IDPH (Illinois Department of Public	F9999		

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F9999	Continued From page 125 Health) information fax sheet accompanying each of the above incident reports. The first fax sheet stated: R16 struck peer in nose for no apparent reason. No apparent injuries to him. To be referred to Psychiatrist. The second fax sheet stated: Resident was struck in the nose by peer R16, causing a nose bleed. Resident transferred to emergency room for evaluation and treatment. Returned x-ray of nose done. No fracture noted. No additional investigation was found or offered by the facility. The facility also failed to show evidence of how the aggressive behaviors of R16 were addressed to prevent further injuries to any residents. -R55: 8/9/2006 at 9:40am, resident (R55) up in chair in the dining area. Informed by staff, resident bit another resident on the arm. Doctor ordered psych evaluation. Witness Account of Events/ fact only: R56 was sitting in his wheelchair, when R55 tried to grab R56. R55 then grabbed R56 and CNA (certified nurse aide) sat R55 down and she got back up and grabbed him again. R56 grabbed R55's chair and started shaking it so that R55 would let go. CNA sat R55 down again and then she got up and grabbed his arm again and bit him until a CNA pulled them apart. R56's skin was torn and bleeding so CNA reported it to the nurse. Supervisor's investigation of event and interventions: resident up in chair in dining area. Informed by staff resident bit another resident on arm in room C4-1. Patient unable to explain why or what happen, due to confusion from traumatic brain injury. No follow-up implementation/ disposition was documented. No documentation of notification to	F9999		

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F9999	Continued From page 126 the state agency. None of the above incident/accidents were investigated by the facility. 5. An incident report for R53 on 3/18/2006 at 8:40am stated, "called to dining area observed patient (R53) on floor on buttock holding on to dining table....no bleeding or skin tear noted. Patient confused but responsive to stimuli. No bruising or swelling noted. PROM (passive range of motion) to all extremities tolerated well. Patient assisted up to wheelchair. Incident was not observed by staff." Supervisor's investigation of event and interventions: Called to dining area, observed patient on floor on buttock holding on to dining table. Patient confused unable to explain. Per interview with nurse resident had no apparent reason to attempt to pick up table in A-wing dining room. Fell with table no injuries noted. Follow-up implementation /disposition: x-ray of pelvis/bilateral hip reveals no fracture- rib x-ray reveals right eight rib with mild displacement. Age of fracture is indeterminate and no bruising or swelling noted on 3/20/2006 at 10:00am. Monitor resident while in dining room-redirect when exhibiting inappropriate behaviors. No notification to state agency. According to the report, R53 was found in the part of the main dining room in which residents from the A-wing are fed by staff. No investigation was conducted beyond follow-up of possible injuries. 6. In addition to the above incident, there were 5 more incidents involving 5 residents with	F9999		

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F9999	Continued From page 127 unknown/unwitnessed injury without any investigation. The incidents were between 2/18/2005 and 7/25/2006 among the facility's incident/accident reports. 7. On 8/15/2006 R46 came to the surveyor and reported that a female had entered his room and took his personal food items. R46 stated she keeps coming into the room. The surveyor asked R46 if he had told staff about the problem. R46 replied, "Yeah, and she came into the room last night." On 8/15/2006, the surveyor presented the problem to E1(Administrator). The next day, the surveyor inquired from R46 if his problem with the female resident had been resolved. R46 replied, "No. She came in my room again and ate my food. Staff did nothing." On 8/17/2006 at the daily status meeting, the surveyor asked E1 how did the facility resolve R46's grievance. E1 stated, the female resident was talked to. 8. The surveyor observed a large number of residents waiting to receive a meal tray on 8/17/2006 at 5:45p.m. in the main dining room. Almost every table in the dining room was occupied by residents. Some of the younger residents were positioned at tables using profanity, having verbal arguments, and some were shouting out to staff for food. The section designated as the feeders' area for residents on the A-wing (designated as the most dependent resident wing) had over six residents positioned at tables and no staff members were in the immediate area. The four staff members in the dining room at the time did not address the	F9999		