STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146071	A. BUILDING _____ B. WING _____	C 11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILTMORE REHABILITATION & NURSING CENTER	**1701 WEST 5TH AVENUE BELVIDERE, IL 61008**

(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 490	Continued From page 25 any further resident input.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240f) Section 300.610 Resident CarePolicies a) The facility's written policies shall be followed in the operation of the facility. Section 3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that the 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 employees of the facility. These regulations are not met, as evidenced by the following: Based on interview and record review the facility neglected: to identify residents who are at an	F9999		

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F9999	Continued From page 26	F9999		

increased risk of being abused and neglected to (1) ensure that all allegations of abuse/neglect are reported to the administrator, (2) thoroughly investigate all allegations of verbal and physical abuse, and (3) initiate a plan to prevent further abuse of residents by R1. This neglect began on 2/14/06 at 12:15 AM when R1 became agitated and pushed R5 off of the 200 wing hall and continued on other occasions when R1 was verbally assaultive and physically abusive towards R4 and R6.

The examples include:

R1's Assessment of 5/13/06 assessed R1 as having no short or long term memory problems and as independent in cognitive skills for daily decision making. R1 was assessed as having behaviors of verbal and physical abuse.

The facility's Incident Notification Form dated 2/14/06 shows that R5 was walking on the 200 unit toward R1's room. R1 spun R5 around and pushed him off the 200 wing toward the 100 wing. E1 (Administrator) was notified.

Review of R1's Nursing Notes from 4/29/06 through 10/2/06 document multiple occurrences relating to R1's uncooperative behavior regarding facility rules, and aggressive behavior toward staff and other residents. Some of the examples include:

6/4/06 4:00 PM entry, a family member was bringing her husband to the front patio and asked R1 to to excuse them to allow space to get the wheel chair out the door. R1 became angry and said to the family member with resident present, "there is another F..cking patio to use." It was

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F9999	Continued From page 27 documented that the resident's wife stated to E2 that this has happened before. 6/30/06 7:30 AM entry, R1 was upset at a confused resident for yelling out in the hallway. R1 came out of his room and shouted to the resident "you M...there F...cker , shut your F...cking mouth." During interview with E8 on 11/8/06 at 8:45 AM, E8 said that R6 is confused and he can't help that he is noisy. R1 will yell at R6 and say "shut up you crazy old man and push him." On 11/8/06 at 8:45 AM E8, said that R4 was yelling. E8 said that R4 can't help that he yells, sometimes he is looking for his wife, or has pain. R1 came out of his room and went down the hallway where R4's room is, I ran after R1. R1 told me to shut up and proceeded to call R4 an "M....there F....cker." E8 said that R4 looked like he was scared. On 10/22/06 8:00 PM, Z4 (Psychiatrist) here to evaluate R1. R1 refused to speak to Z4, there was an argument that ensued and the police were notified to come to the facility at the request of Z4. The October, 2006 Physician's Order Sheet documents an order from Z4 that R1 is not to leave the facility and that R1 is a suicide and elopement risk. E1 (Administrator) was notified. During an interview conducted on 11/8/06 at 3:30 PM, E1 (Administrator) said that he was not aware of the incidents involving R4 and R6. E1 said that when he read R1's Nurse's Notes since admission "It was bad." E1 confirmed with this surveyor that the facility had not identified residents who would be at increased risk for	F9999		

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F9999	Continued From page 28 abuse and neglect related to their disruptive behavior. E1 verified that there were no incident reports completed for R4 and R6 when they were verbally and physically abused by R1. During an interview conducted on 11/8/06 at 4:15 PM E7 (Social Services Director) said that she was not aware of all the incidents of verbal and physical abuse towards other residents documented in R1's chart. E7 confirmed that the incidents documented in R1's chart were abusive and should have been investigated. The facility was unable to provide any documentation showing that they put approaches/interventions in place to prevent further abusive behavior by R1. The facility's Policy on Abuse And Neglect dated 11/8/06 states, "The facility will conduct an investigation of an alleged abuse/neglect or misappropriation of resident property in accordance with state law. The facility will report such allegations to the state, as per state regulation. The facility will investigate all patterns, trends, or incidents that suggest the possible presence of abuse, neglect or misappropriation of property, identified through analysis conducted by the collaboration Committee, with intervention, reporting or policy/procedure modification conducted as appropriate." (A)	F9999		