

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/09/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN ALMA NELSON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108</b>		
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F 387	Continued From page 17 effectiveness. Potassium chloride - requires monitoring of potential toxic sub-therapeutic levels. Sinemet - Antipsychotics may inhibit the antiparkinsonian effects of levodopa - monitor for reduced effect. Depakote - requires monitoring of therapeutic levels and effectiveness. Razadyne - monitor for therapeutic dosage and renal or hepatic impairments. Namenda - monitor for therapeutic effectiveness, and renal impairment Mirapex - monitor of therapeutic effectiveness and blood pressure changes. Pravachol - monitor lab values and patient response. Aspirin - monitor lab values and patient response. Sonata - failure of sleep disturbances to resolve after 7-10 days may indicate psychiatric and or medical illness.	F 387			
F9999	FINAL OBSERVATIONS  STATE VIOLATIONS  300.610a) 300.1210a) 300.1210b)3) 300.1210b)6) 300.3240a)b)f)  Section 300.610 Resident Care Policies 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	F9999			

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F9999	<p>Continued From page 18</p> <p>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 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>b) 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>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.</p> <p>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.</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</p>	F9999			

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F9999	<p>Continued From page 19 resident.</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.</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.</p> <p>These regulations are not met as evidenced by the following:</p> <p>Based on interview and record review the facility failed to:</p> <ol style="list-style-type: none"> <li>1] Screen residents for their risk of being a victim of abuse (R1, R8, R7),</li> <li>2] Implement preventative measures to ensure that residents are protected from abuse,</li> <li>4] Supervise R2 to prevent him from assaulting other residents, and</li> <li>5] Implement strategies to reduce or eliminate such altercations.</li> </ol> <p>This applies to 3 residents who were physically abused by another resident (R1, R7, R8) and 1 resident who was the abuser or aggressor of incidents (R2).</p> <p>These failures resulted in R2 striking R8 on the leg on 11/14/06, striking R7 in the chest during 12/06, and repeatedly striking R1 on/about the face causing facial trauma and a subdural</p>	F9999			

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F9999	<p>Continued From page 20 hematoma on 1/29/07.</p> <p>Findings include:</p> <p>EXAMPLE #1</p> <p>R2's physician order sheet dated 1/7/07 lists R2's diagnoses as Dementia, Alzheimer's disease and Parkinson's disease. The progress notes dated 11/15/06 by Z2 (psychiatrist) show R2 to have impaired impulse control, impaired insight and impaired judgment. R2 sleeps fair, is slightly depressed, moderately anxious and agitated and slightly psychotic.</p> <p>The resident assessment tool dated 1/20/07 shows R2 to have short and long term memory problems and is moderately impaired in cognitive skills for daily decision making. The assessment states R2 is easily distracted, has altered perceptions of surroundings, has periods of restlessness and his mental function varies during the course of the day. R2 makes frequent negative statements, displays anger with self and others and his mood is not easily altered. R2 requires limited assistance with activities of daily living and is independent in moving around his room and corridor. The assessment analysis dated 10/20/06 states, "Resident appears more confused in the evening and could possibly be sundowning." The assessment analysis, under psychotropic drugs states, "Resident can become agitated often. Wife used to visit daily and is unable to visit as often at this time. Medications appear effective at this time."</p> <p>On 2/1/07 at 11:55 AM, E10 (Licensed Practical Nurse - LPN) stated, "R2 has tried to hit staff. He has very extreme moods; he is either really nice</p>	F9999			

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F9999	<p>Continued From page 21</p> <p>or really irritated. R2 can wake up mad and 5 minutes later be a different person. The doctor had taken R2 off his psych meds and his behaviors were starting to change. He was like a zombie before so they decreased them. R2 was coming off his meds and his long time roommate died in December. When they moved R1 (victim) into R2's room I knew right away he wouldn't like it." R1 would lie in bed yelling, especially after his family would leave. R1 would be very frustrating to live with. He can be very trying with the staff. He yells out at night.</p> <p>On 2/1/07 at 2:25 PM, E7 (LPN) stated, "R2 had no sense of safety awareness; he knew to take off his chair or bed alarm. He would disconnect the alarm and hide it under his pillow in his bed. R2 had trouble sleeping, the doctor started Sonata (sleep medication). We give it to him if he wakes up in the night. R1 (victim) only spoke Spanish and even the family stated they could not understand his speech. R1 (victim) had repetitive verbalization, could go longer than 15 minutes at a time, then stop only to start up again. We medicate him with Ativan (anti-anxiety medication) a couple times a day and that seems to help some. R1 (victim) wears protective hand mitts to prevent him from pulling out his feeding tube. At times R1 (victim) can get so agitated he bites off the mitts."</p> <p>On 2/1/07 at 2:40 PM, E6 (Certified Nursing Assistant - CNA) stated, "R2 would get really mad at R1 (victim) about his jabbering. R1 would jabber nonsense in Spanish, and R2 would yell at him to stop. We tried to keep R1 (victim) up in the chair to fatigue him so he would sleep better and not bother R2 so much."</p>	F9999			

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F9999	<p>Continued From page 22</p> <p>On 2/6/07 at 1:15 PM, Z2 stated, "R2 is psychotic. He is impaired in his judgment and impulse control. He doesn't care who he hurts. It is not unexpected for a resident with this type of psychosis to do that (violent behavior)." Z2 stated he was aware that R2 has had previous assaultive behaviors.</p> <p>R2's care plan dated 1/20/07 does not identify problems of R2's agitated and assaultive behaviors nor are there any interventions in place for these behaviors.</p> <p>On 2/5/07 at 2:30 PM, E13 (CNA) stated, "On Sunday (1/28/07) around 9:45 PM, the nurse asked me to take R2 to the TV lobby because he tried to beat up R1 (victim). I asked R2 what's the problem, and R2 told he that he was trying to sleep and R1 keeps talking non-stop. I told him to stay in the TV room." E13 stated no additional checks were made because she got off duty at 10:00 PM. "On Monday (1/29/07) around 9:00 PM, I put R2 to bed. I left the door open and turned on R1's light. A little later, R2 was awake, trying to get out of bed. R2 told me "He's bothering me again, turn off his light." I turned off the room light and asked R2 to go back to bed and he said "OK." R1 (victim) was quiet at this time, it was just the room light that was bugging R2 so I turned it off." E13 described R1's verbalizations as, "Non-stop monotone jabbering. R1 does it more in the late evening, he is quiet when he is in the chair, then we put him to bed and he sleeps for a short while. Then R1 wakes up and starts the rambling. R2 has trouble sleeping so he stays up late. About the time he tries to go to sleep, R1 starts in with his talking."</p> <p>On 2/1/07 at 12:20 PM, E11 (CNA) stated, "I was</p>	F9999			

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F9999	<p>Continued From page 23</p> <p>working night shift on 1/29/07. R1's room was the last room to check on my shift rounds. The light was off in the room. I found R1 (victim) with blood all over his face, sheets, night gown and wall. R1 (victim)'s right eye was starting to swell. The blood on his face was dry, but it was damp on his neck and sheets. When I tried to take his blood pressure, he pulled his arm up to his face like it hurt. R2 was just lying in bed like nothing was going on. I was suspicious and checked R2's hand. It was swollen with blood on it." E11 continued, "I had heard that previously R2 had been hitting R1 (victim). I did not see anything, but I know another girl on my shift told me she saw R2 threatening R1 (victim) with his fist." E11 stated, "R2 was combative with the staff. He would swing at you with his fist." E11 continued, "R1 (victim) yells out in Spanish and that irritated R2. He repeats the same thing and is very loud."</p> <p>On 2/7/07 at 2:20 PM, E14 (LPN) stated, "At 11:20 PM, the night aid told me to come and see this. R2 was lying in bed licking blood off his fingers. R1 (victim) was just a mess. R1 had mitts on both hands to prevent him from pulling on his feeding tube. The palms of both mitts were covered with blood. With the mitts on he couldn't protect himself. R1 had been quiet that night. He had to have been sleeping; I had just given him his medication 1 hour before. He couldn't have been provoking. When I went up that hall at about 11:15PM, the door to their room was shut and it was quiet. I never heard anything. I had read on the nursing communication sheet that R2 had been found the night before standing over R1's bed. I documented what I saw in the nursing notes. The DON wrote what I told her about how I found them on the report. No one has talked to me</p>	F9999			

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F9999	<p>Continued From page 24 since then about the incident."</p> <p>The hospital Emergency Physician Record for R1 (victim) dated 1/29/07 listed the clinical impression as contusions to the head and face and a subdural head injury. R1 had a 1 cm laceration on the right cheek requiring sutures for closure. The hospital Emergency Nursing Record for R1 dated 1/29/07 documented, "Purple bruising and swelling of the right orbit, gross swelling and purple bruising of right cheek with puncture wound, purple bruise and swelling of the lower lip, and a deep purple bruise of the right jaw.</p> <p>The facility incident report dated 1/29/07 at 11:25PM for R1 (victim) states, "Found resident lying in bed apparent battering incident. Right side of face edematous, ecchymotic, right and left orbits (eye area) becoming edematous, light ecchymosis appearing about the orbits. Large blood clots to left side of face. Small amount blood splattered on wall."</p> <p>The facility incident report dated 1/29/07 at 11:25 PM for R2 (aggressor) states, "Possible abuse behavior - resident found licking blood from his fingers." Resident assessment showed the second, third and fourth digits of the right hand edematous and ecchymotic.</p> <p>The facility incident report sent to IDPH on 1/30/07 states, "On 1/29/07 at 11:25 PM, resident (R1 victim) found in bed with laceration and swelling to facial area. Roommate (R2) was noted to have swelling on hand with blood."</p> <p>On 1/31/07 at 11:05 AM, E1 (Administrator) stated regarding the assault investigation, "We</p>	F9999			



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F9999	<p>Continued From page 25</p> <p>know what happened. R2 got aggravated with R1 (victim), got up and beat him up. This behavior hasn't been an issue before. We don't know why it happened. I was shocked when I heard about it." E1 continued, "R1 (victim) was on the E wing and we moved him in with R2 on the D wing. We thought it would be a good match because they are both Hispanic. We just found out in talking to the family that R2 used to be a boxer in his youth."</p> <p>On 1/31/07 at 11:15 AM, E2 (Director of Nurses - DON) stated, "Both residents (R1, R2) are new to me." E2 was questioned about a precipitating event, and replied, "I'm not sure." I was called in to take a look. R1 (victim) was battered. He was slowly responding, his eyes were swollen; there was blood from a hematoma on his cheek and splattered on the left side of his face. R2's hand was swollen."</p> <p>On 1/31/07 at 2:25 PM, E7 (LPN) stated, "The next day was a normal day for R2. He acted as if nothing had happened. We didn't have to do anything different for him."</p> <p>Record review of R2's nurses' notes dated 1/30/07 show R2 was observed at 1:00 AM and that he went to bed at 1:30 AM. The next resident observation was at 8:30 AM when his Right hand was x-rayed. The last entry was at 5:30 PM that documents R2 was transferred out of the facility. "R2 was restrained due to refusing to cooperate with ambulance staff. R2 was physically abusive to staff."</p> <p>On 2/1/07 at 11:25 AM, E8 (Asst Administrator/Social Services) stated regarding behavior monitoring, "Residents with behaviors</p>	F9999			

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F9999	<p>Continued From page 26</p> <p>are referred to social services from staff. They submit a referral form to me. I address the behavior; try to figure out why the resident is acting that way. I review the forms for any behavior changes and make referrals as needed. R2 was not on the list for behavior monitoring. I did not have any reports of behaviors."</p> <p>In addition to the assessment of the presenting injuries, the hospital Emergency Nursing Record for R1 dated 1/29/07 documented, "Yellow and green bruising noted around left eye orbit, green and light purple bruising of the left jaw, and yellow bruise to the upper left thigh, yellow green bruise above the left knee, yellow bruise on left shin, and 2 yellow bruises on the right knee. Abrasions noted on the left knee and shin."</p> <p>On 2/8/07 at 10:50 AM, Z3 (physician) stated, "R1 had an old black eye on the left side and the left jaw also had an old bruise. The new trauma was on the right side of R1's face." The nurses' notes dated 1/20/07 for R1 document, "CNA observed a bruise/discoloration, purple/red to the left side by his mouth. CNA observed this during shower time."</p> <p>On 2/1/07 at 11:20 AM, E1 (Administrator) was requested to provide the investigations regarding the bruises of unknown origin in the past 3 months. E1 provided two reports. E1's comments about R1's report included, "Yes, I did that. They think he bumped his jaw on the side rail of the bed. We took the rail off his bed." The report did not include any conclusions regarding the bruising to left eye, and both lower legs.</p> <p>EXAMPLE #2</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>The Physician order sheet dated 1/07 lists R8's diagnoses as Hypertension and Dementia. The resident assessment tool dated 11/2/06 shows that R8 does not have any mood or behavior issues. The assessment analysis tool dated 8/2/06 states R8 is alert and oriented but has bouts of forgetfulness. R8 is observed as intellectually deprived.</p> <p>The nurses' note for R8 dated 11/14/06 at 1:40 PM documents, "Resident sitting in stationary chair in lobby and was approached by another resident (R2) and was struck in the left mid outer thigh several times." R2's 11/14/06, nurses' note, at 1:45 PM documents, "Resident approached other resident (R8) in the lobby, striking him several times with his fist on the left outer thigh."</p> <p>Incident investigation interview with R8 dated 11/15/06 stated, "I was just sitting up front in the chair and R2 was sitting next to me. He kept getting up and people kept sitting him back down. Then he just hit me on the leg. I was just sitting there and he hit me. I just sit somewhere away from him (R2) and he don't do that anymore."</p> <p>On 2/7/07 at 11:00 AM, E1 (Administrator) stated, "The incident between R2 and R8 was investigated. R8 was not hurt." E1 stated R8 did not need any further monitoring or assistance because he talks to him and R8 would say something if he was bothered by R2.</p> <p>Review of R8's care plan showed he was not identified as a victim of abuse. The care approaches for monitoring and ensuring his safety from further incidents was not listed.</p> <p>EXAMPLE #3</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/09/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN ALMA NELSON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108</b>		
(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	
F9999	<p>Continued From page 28</p> <p>On 2/1/07 at 11:40 AM, E9 (CNA) stated, "This isn't the first time R2 has been in a fight. In December while at the dining room table, R2 hit R7 in the chest with his fist. After that, we had to move him (R2) to another table."</p> <p>On 2/6/07 at 3:20 PM, E1 (Administrator) stated he was not aware and did not have an incident report regarding an incident between R1 (victim) and R7.</p> <p>Review of R7 ' s care plan showed he was not identified as a victim of abuse. The approaches for monitoring and ensuring safety from further incidents are not listed.</p> <p>Facility Policy &amp; Procedure: Reference to the facility policy on Abuse Reporting N-1020: Page 1, "All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of an unknown source. Our facility will not tolerate resident abuse." Page 2, a. "Abuse is defined as willful infliction of injury. d. Physical abuse is defined as hitting, slapping, pinching."</p> <p>Facility policy Abuse and/or Resident Neglect Investigation Ns-1000: Page 1, "The alleged victim will be assessed for ..... emotional distress."</p> <p>Facility In-service Education Manual: Module 7, Ethical and Legal Issues of Reporting Suspected Abuse, Page 7, "Staff members should know how to report the incident using the chain of command within the facility." Module 8, "Conflict between residents, between</p>	F9999			

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NAME OF PROVIDER OR SUPPLIER  <b>ALDEN ALMA NELSON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 SOUTH MULFORD AVENUE</b> <b>ROCKFORD, IL 61108</b>		
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F9999	Continued From page 29 residents and staff, directly influences the quality of life for residents."  (A)	F9999			