STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145905	A. BUILDING _____ B. WING _____	11/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHABILITATION & HCC	ROUTE 127, PO BOX B JONESBORO, IL 62952

(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 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey for Subpart S: SMI Complaint Investigation 1153190/IL54888- F223, F225, F226 and F514 were cited. An extended survey was conducted.	F 000		
F 223 SS=G	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that residents are kept free from physical abuse for 1 of 14 residents (R4) reviewed for physical abuse in the sample of 14. This failure resulted in R4 sustaining skin tears to hands and arms, black eyes, and bruising to the face. Findings include: 1. R4 is a 92 year old woman who resides in the facility since 6/3/2008 according to her admission record. The facility diagnoses sheet updated 5/7/2011 lists her diagnoses as follows:Chronic Anemia, Congestive Heart Failure, Kidney	F 223		11/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Disease, Hypertension, Dementia, ORIF left Hip with Trocho-nail, and Chronic Bilateral Lower Extremity Edema.

The most recent Minimum Data Set for R4 is a quarterly assessment dated 10/25/2011 and indicates minimal difficulty hearing, visual impairment, BIMS (Brief Interview for Mental Status) summary score is 99 indicating R4 was unable to complete the interview, long and short term memory problems, and moderately impaired cognitive skills for daily decision making. R4 requires 1 or more staff assistance for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. R4 is incontinent of bowel and bladder. R4 is ambulatory per wheelchair. The Behavioral Symptoms section of the Minimum Data Set of 10/25/2011 notes physical behavior symptoms directed toward others and verbal behavioral symptoms directed toward others which occurred 1 to 3 days of this assessment. The Care Plan for R4 dated 8/5/2011 includes a concern that R4 have fewer episodes of resistive or combative behavior during A.M. (morning) care.

On 8/29/2011 the facility filed a report with the Illinois Department of Public Health of an Investigation of Possible Neglect/Abuse of an incident on 8/27/2011 involving R4. The report notes on 8/27/2011 during morning care R4 sustained a skin tear to her hand, and on 8/29/2011 R4 was noticed to have faint discoloration on the right side of her face. During this investigation the facility notes that multiple staff interviews were conducted and two Certified Nurse Aides E4 and E8 present during the incident stated that E7 the third Certified Nurse

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Aide was "too rough" while trying to assist R4 getting dressed. E7 stated she felt the skin tear was caused by her watch.

On 8/27/2011 E7 (Certified Nurse Aide) provided the facility a written statement of the incident. In this statement E7 writes R4 was "resistive to care when we were cleaning her up from having a bowel movement and she was grabbing my arms, biting me, and grabbing my clothes, it was then that we noticed the skin tears to her hands and arms. We notified E11 (Registered Nurse) and she bandaged it up." No written statements were obtained from other staff on 8/27/2011.

On 8/29/2011 E2 (Director of Nurses) initiated further inquiry into this incident. On 8/29/2011 E7 (Certified Nurse Aide) was interviewed at the facility by E2 and provided details of the incident. In this interview E7 states R4 "had a bowel movement and we were trying to clean her up, she was scratching and fighting." E7 identifies E4 and E8 (Certified Nurse Aides) as two other staff persons in attendance during this incident. E7 continues the interview by stating R4 was flailing her arms around and "I think it was my watch that cut her hand". E7 adds that" there was no bruise or redness on the right side of R4's face at this time".

On 8/29/2011 at the facility E2 (Director of Nurses) interviewed E4 (Certified Nurse Aide) of the incident on 8/27/2011 involving R4. E4 wrote in the statement that R4 "had a bowel movement and we were trying to clean her up". E4 identifies E7 and E8 (Certified Nurses Aides) as also being present during this incident. E4 stated that E7 was arguing with R4 and was swearing calling R4

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a "bitch" and E7 pulled R4's hair. In conclusion of this statement E4 writes "it is my observation that E7 is argumentative with residents, swears at them, and is too rough".

On 8/29/2011 at the facility E2 (Director of Nurses) interviewed E8 (Certified Nurse Aide) of the incident on 8/27/2011 involving R4. E8's written statement notes "E7 (Certified Nurse Aide) was grabbing R4 too rough, she also called R4 an "old bitch" and was pulling her hair.

On 8/30/2011 at the facility E2 (Director of Nurses) interviewed E9 (Registered Nurse) about the incident on 8/27/2011 involving R4. E9 stated E4 and E7 (Certified Nurse Aides) "were dealing with R4 and R4 was trying to get up out of her chair and E7 was trying to put R4 back in the chair and grabbed her hair by accident."

On 8/30/2011 at the facility E2 (Director of Nurses) interviewed E11 (Registered Nurse) about the incident on 8/27/2011 involving R4. E11 stated E8 (Certified Nurse Aide) told her someone was needed in R4's room, R4 was combative and had a small skin tear on her forearm. E11 responded and noticed a large skin tear on the top of R4's left hand. E11 spoke with E7 (Certified Nurse Aide) who stated "her keys or her watch could have caused the skin tear." E11 talked to E4 (Certified Nurse Aide) and asked what happened, E4 (Certified Nurse Aide) stated she "did not know what E7 was doing but she did see E7 grab R4's hair. E11 again spoke with E7 about the incident and E7 stated "R4 was leaning forward and when E7 went to pull R4 back E7 accidentally grabbed R4's hair."

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F 223	Continued From page 4 On 10/26/2011 at 8:50 am a telephone interview was conducted with E7 (Certified Nurse Aide) involving the incident on 8/27/2011 with R4. E7 was asked to provide a detailed statement of the events of the incident of 8/27/2011. E7 stated " Saturday morning 8/27/2011 around 6:30 am working with E4 and E8 (Certified Nurse Aides) we went to get R4 up for the morning. R4 was combative, pulling at us, scratching us, grabbing the under part of our arms, we were going to set her back down and try again later but she would not let us go so we put her in the wheelchair. R4 had a bowel movement and I sent E8 (a new girl) to go get washcloths and supplies so we could clean her up. I don't know how the skin tears happened it was either because R4 has thin skin or by my watch". When we noticed the skin tears I sent E8 to get the nurse. When E7 was asked at anytime did she or any other staff person intentionally or unintentionally harm R4, E7 stated "no, I would never hurt one of these older people who cannot take care of themselves, I am here to help them." When asked what happened next, E7 stated I was asked to give a statement to the nurse E11 (Registered Nurse) and I did. I worked Saturday and Sunday, on Monday I was called to the facility and questioned by E2 (Director of Nurses) and E1 (Administrator), on Monday I was suspended and by Wednesday I was terminated. E7 was asked for what reason she was terminated and she said "I was told I broke a rule but I believe it was because of what happened to R4". E7 stated she was told she had hit R4 with her fist and that R4 had massive bruises all over her face. E7 stated of the three staff working with E7 during the incident she was the only person terminated.	F 223		

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On 10/26/2011 at 9:15 am a telephone interview was conducted with E4 (Certified Nurse Aide) involving the incident on 8/27/2011 with R4. E4 was asked to provide a detailed statement of the events of the incident of 8/27/2011. E4 stated it was on a Saturday about 6-6:30 am at the beginning of the shift, I was working with E7 and E8 (Certified Nurse Aides), E8 was new still in orientation. We went to get R4 up, I believe out of fear of falling, R4 had broken her hip in May reached out for support and grabbed E7's arms digging her fingernails into E7's arms, E7 in return dug her fingernails into R4's arms scratching her. E7 was calling R4 names, E7 shook R4, pulled R4's hair so hard there was hair in E7's hand, and E7 slammed R4 down into the wheelchair. I yelled E7 "stop that you are hurting R4", R4 was screaming, there was blood on R4's arms. E7 was out of control and not listening to me. E8 went and got the nurses E9 and E11(Registered Nurses), E9 and E11 took R4 into the bathroom and treated her arms. I immediately reported what happened on 8/27/2011 to E11 and E9. I worked a double shift on Saturday and Sunday, on Monday 8/30/2011 I was called into the office and questioned about the incident by both E1 (Administrator) and E2 (Director of Nurses) and I told them what happened, they said I did the right thing by reporting it, I did not get into trouble. I heard through hearing other staff talk that E7 was terminated because of what she did to R4. I don't know what happened to E8 (the new girl) she stopped working there soon after.

On 11/02/2011 at 1:55 pm a telephone interview was conducted with E8 (Certified Nurse Aide) involving the incident on 8/27/2011 with R4. E8

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was asked to provide a detailed statement of the events of the 8/27/2011. E8 stated " I had been working there only a couple of weeks and I was placed on a hall with E7 and E4 (Certified Nurse Aides). E7 was hollering at R4 and put her weight on R4 holding R4 down, R4 was trying to get up and screaming. E7 was roughing up on R4 and pushed R4 down in the chair. R4 needed to be cleaned up again so E7 and E4 told me to go get supplies to clean R4 up with, I left the room. When I returned to the room E4 was telling E7 to leave the room E7 was too worked up. E7 had a handful of R4's hair I saw her pull out R4's hair, I heard E7 call her "an old bitch", then I saw two big gashes on R4's hands, they told me to get a nurse. I did not see how R4's arm got injured. That same day 8/27/2011 I was questioned by E11 (Registered Nurse) as to what happened, E11 told me since I was new I didn't have to get involved and I didn't need to write a statement just tell her what happened and I did. E7 was fired due to abuse to R4. A few days later I noticed R4 had two black eyes and one side of her face was bruised. I was fired and the reason I was given was because of no call no show which was not true."

On 11/2/2011 at 2:30 pm in the social service office at the facility an interview was conducted with E9 (Registered Nurse) involving the incident on 8/27/2011 with R4. E9 was asked to provide a detailed statement of the events of 8/27/2011. "On 8/27/2011 R4 had a skin tear that morning, me and E11 (Registered Nurse) responded. E4, E8 and E7 (Certified Nurse Aides) were working in that room. I saw blood from a skin tear on R4's wrist, we took R4 into the bathroom on 100 hall because R4 was living on 100 hall at that time to

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clean it up. R4 was upset I thought it was because of the skin tear or because too many people were around, that sometimes upsets R4. There was one skin tear on the back of her hand and a scratch possibly on one arm. I can't remember if we put anything on it or not. R4 was not my resident so E11 filled out the skin tear papers, incident report and questioned staff as to what happened". E8 was questioned and asked what happened E8 said "we were getting R4 up and R4 was resisting care, flailing her arms and hit her hand, R4 was falling out of the chair and E7 reached for R4 pulling her hair but not intentionally. When asked about bruises to R4's face E9 stated " I knew nothing about this until E2 (Director of Nurses) asked me to come in an give a statement, it was then that I noticed the bruises, this was on Monday, I never noticed anything on Sunday." E9 was asked to describe the bruises to R4's face and E9 said " the bruises were on the right side in the cheek area, it was yellowish and it was large enough you could see it.

On 11/03/2011 at 9:00 am E14 (Registered Nurse/Charge Nurse) was interviewed about bruises and black eyes on R4. E14 denied seeing or having knowledge at any time of R4 having bruises or black eyes.

On 11/03/2011 at 9:30 am E3 (Assistant Director of Nurses) was interviewed about bruises and black eyes on R4. E3 denied seeing or having knowledge of black eyes on R4 but stated in the right lateral eye area there was a faint yellow bruise that was visible when you looked at R4 head on.

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On 10/26/2011 at 10:45 am in a designated work area at the facility E2 (Director of Nurses) was interviewed about skin tears and bruises on R4. E2 stated skin tears were evident on 8/27/2011 but there was no bruising to the face at this time. Around 8/29/2011 bruising was noted to the face, the bruise was faint, I don't remember what side it was on, seems like it started in the temple area and went to the cheek. On 11/03/2011 at 10:00 am E2 was asked at any time did R4 have black eyes, E2 stated "yes, on 8/29/2011."

On 11/03/2011 at 1:20 pm in the social service office at the facility E12 (Certified Nurse Aide) was interviewed about bruises and black eyes on R4. E12 stated "I was off on 8/27/2011 and 8/28/2011, I returned to work on Monday 8/29/2011 and R4 had a black right eye and bruises on her neck. On 8/30/2011 the bruising had spread across her face to both eyes and R4 looked like a little raccoon, that pissed me off that someone would hurt R4."

On 11/03/2011 at 1:40 pm in the social service office at the facility E4 (Certified Nurse Aide) was again interviewed about the incident on 8/27/2011 with R4. During this interview E4 was asked what day, what time, and to whom did she report this incident. E4 stated "I reported it within a few minutes of it happening I went to E9 and E11 (Registered Nurses) and asked to speak with them, we went into E2's (Director of Nurses) office to talk." What did you tell the nurses. " I said that I felt E7(certified Nurse Aide) was too rough and aggressive and what happened to R4 did not need to happen." E7 was asked where did the incident occur and E4 stated" it happened in R4's room on 100 hall." What did you tell the

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F 223	Continued From page 9 nurses happened, I told them that E7 pulled R4 roughly to the side and tugged her back and forth, cursing her, calling her names, E7 had hold of R4's hair and was pulling it, and pulled it out. I told E7 that was enough as E7 had R4's feet off the ground. The skin tear to the back of R4's hand was directly due to E7's roughness, E7 tore the skin off. E9 and E11 thanked me and said they would tell E2 (Director of Nurses). On 11/04/2011 at 10:10 am in the social service office at the facility E11 (Registered Nurse) was interviewed about the incident on 8/27/2011 involving R4. E11 stated E7 (Certified Nurse Aide) told her someone was needed in R4's room, R4 was combative and had a small skin tear on her forearm. E11 responded and noticed a large skin tear on the top of R4's left hand. I spoke with E7 who stated "her keys or her watch could have caused the skin tear." I talked to E4 (Certified Nurse Aide) and asked what happened, E4 stated she "did not know what E7 was doing but she did see E7 grab R4's hair." I again spoke with E7 about the incident and E7 stated "R4 was leaning forward and when E7 went to pull R4 back E7 accidentally grabbed R4's hair." When asked about bruises to R4's face E11 stated I saw the bruises that following Tuesday when I came into the facility to give a statement. The bruise was on the right cheek bone and it was yellow-green in color. I did not see R4 with black eyes.	F 223		
F 225 SS=L	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		11/22/11

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F 225	Continued From page 10 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to conduct a thorough and	F 225		

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comprehensive investigation of an allegation of physical abuse, implement preventive measures to protect a resident from actual harm and potential future harm, immediately notify the administrator of the allegation of physical abuse, and failed to notify the state agency and law enforcement within 24 hours of the allegation of abuse for 1 of 14 residents (R4) reviewed for physical abuse in the sample of 14.

These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 11/03/2011 when the facility staff received in-service on thorough investigation and reporting of allegations of abuse, staff reviewed the Abuse Policy including identification of abuse allegations, protection of residents by removal of the alleged perpetrator pending outcome of the investigation, and timely notification to the Administrator, state agency and law enforcement, the facility remains out of compliance at a level that is not actual harm with the potential for more than minimal harm due to revisions and additions to the Quality Assurance measures that require monitoring and follow-up.

This failure also has the potential to harm all 52 residents residing in the facility.

Findings include:

R4 is a 92 year old woman who resides in the facility since 6/3/2008 according to her admission record. The facility diagnoses sheet updated 5/7/2011 lists her diagnoses as follows:Chronic Anemia, Congestive Heart Failure, Kidney Disease, Hypertension, Dementia, ORIF left Hip with Trocho-nail, and Chronic Bilateral Lower

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JONESBORO REHABILITATION & HCC	ROUTE 127, PO BOX B JONESBORO, IL 62952

(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 225	Continued From page 12 Extremity Edema. The most recent Minimum Data Set for R4 is a quarterly assessment dated 10/25/2011 and indicates minimal difficulty hearing, visual impairment, BIMS (Brief Interview for Mental Status) summary score is 99 indicating R4 was unable to complete the interview, long and short term memory problems, and moderately impaired cognitive skills for daily decision making. R4 requires 1 or more staff assistance for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. R4 is incontinent of bowel and bladder. R4 is ambulatory per wheelchair. The Behavioral Symptoms section of the Minimum Data Set of 10/25/2011 notes physical behavior symptoms directed toward others and verbal behavioral symptoms directed toward others which occurred 1 to 3 days of this assessment. The Care Plan for R4 dated 8/5/2011 includes a concern that R4 have fewer episodes of resistive or combative behavior during A.M. (morning) care. On 8/29/2011 the facility filed a report with the Illinois Department of Public Health of an Investigation of Possible Neglect/Abuse of an incident on 8/27/2011 involving R4. The report notes on 8/27/2011 during morning care R4 sustained a skin tear to her hand, and on 8/29/2011 R4 was noticed to have faint discoloration on the right side of her face. During this investigation multiple staff interviews were conducted and two Certified Nurse Aides E4 and E8 both present during the incident stated that E7 the third Certified Nurse Aide was "too rough" while trying to assist R4 getting dressed. During this investigation E7 was asked about the cause	F 225		

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of the skin tear to R4's hand, E7 stated she felt the skin tear was caused by her watch while she was providing care.

The facility was aware of the allegations of physical abuse which resulted in injuries to R4 and did not conduct a thorough and comprehensive investigation of the allegations as follows: A review on 10/26/2011 of statements given to the facility on 8/29/2011 by E4 and E8 (Certified Nurse Aides) describe hearing and seeing acts of physical abuse and mistreatment by E7 (Certified Nurse Aide) against R4, resulting in injuries to R4. During interviews with E4 on 10/26/2011 and 11/03/2011 E4 stated the allegations of physical abuse were reported to E9 and E11 (Registered Nurses) on 8/27/2011 shortly after they happened, and E4's statements were repeated to E2 (Director of Nurses) during an investigation on 8/29/2011. During an interview on 11/02/2011 with E8, E8 stated she was told by E11 because she was new she did not need to get involved, and did not need to provide a written statement, to just tell what happened. E8 also provided a written statement of the allegation of physical abuse to E2 on 8/29/2011 during the investigation.

The facility did not implement preventive measures to protect R4 from actual harm and potential future harm during the investigation into allegations of physical abuse involving R4 as follows: A review on 10/26/2011 of the facility's employee work schedule for August 2011 note E4, and E7 (Certified Nurse Aides) worked day shift 6am-2 pm on 8/27/2011. E8 (Certified Nurse Aide) was in orientation and was assigned to work with E7 according to the facility's August

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F 225	Continued From page 14 27, 2011 daily schedule. Per interviews on 10/26/2011 and 11/02/2011 with E4, E7 and E8 all stated they were present on 8/27/2011 and working with R4 when the injuries occurred and were allowed to continue working their assigned shift providing direct care to residents including R4 on 8/27/2011 and 8/28/2011. The facility did not immediately notify the Administrator of the allegation of physical abuse on 8/27/2011 involving R4 as follows: During interviews on 10/26/2011 when asked about notification of the allegation of physical abuse involving R4 E1 (Administrator) stated "I found out on Monday 8/29/2011 when E2 (Director of Nurses) called me at home," E2 (Director of Nurses) stated "on Monday morning 8/29/2011 when I was asked if I had seen the bruising to R4's face, but I did receive notice of the skin tears on 8/27/2011", and E3 (Assistant Director of Nurses) stated "Monday morning 8/29/2011 when I heard staff talking about bruising to R4's face." The facility did not timely notify the Illinois Department of Public Health, Marion Regional Office, Division of Long Term Care of the allegation of physical abuse which occurred on 8/27/2011, notification was received on 9/06/2011, notification was not made to the local police as follows: On 10/26/2011 at 10:00 am E1 (Administrator), was interviewed , E1 stated that facility staff did not call the police at any time during the investigation. A review on 10/26/2011 of the facility's Abuse Prevention Program notes that the program does not address immediate notification to the administrator by staff other than supervisors. The Abuse Prevention Program does not address Section 1150 B of the Social	F 225		

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Security Act that became effective on 3/23/2011. Section 1150 B establishes two time limits for the reporting of reasonable suspicion of a crime. The first is a 2 hour notification if the events "that cause the reasonable suspicion result in serious bodily injury to a resident", and the second is within 24 hours if the events "that cause the reasonable suspicion do not result in serious bodily injury to a resident." Notification to the police of reasonable suspicion of a crime was required using either time frame established in Section 1150 B of the Act.

During the interview with E1 on 10/26/2011, E1 also stated that notification of the incident was sent to IDPH on 9/2/2011 the date the Investigation of Possible Neglect/Abuse report was completed. A report of Investigation of Possible Neglect/Abuse dated 9/2/2011 was received by facsimile and recorded at the Regional Office of the Illinois Department of Public Health (IDPH) on 9/6/2011. This report documents that the facility investigated an allegation of verbal and physical abuse involving R4, a 92 year old resident, and a staff person E7 (Certified Nurse Aide) , that occurred on 8/27/2011, that E2 (Director of Nurses) received notification on 8/27/2011 of a skin tear to R4's hand, that the source of the complaint is resident observation, and that an investigation was started on 8/29/2011.

A review on 11/11/2011 of the Marion Regional Office of the Illinois Department of Public Health's Incident Report file noted (IDPH) did not receive from the facility an incident report of an allegation of physical abuse involving R4 occurring Saturday morning 8/27/2011.

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The Facility Data Sheet form completed by E1 (Administrator) on 10/25/2011 documents that the facility census was 52.

The Immediate Jeopardy was identified on 11/03/2011 at 11:00 am, E1 (Administrator), E2 (Director of Nurses) and E3 (Assistant Director of Nurses) were notified at that time. The Immediate Jeopardy was determined to have begun on 8/27/2011 when the facility failed to thoroughly and comprehensively investigate an allegation of physical abuse, protect the resident from actual and future harm during the investigation, immediately notify the Administrator, and timely notify Illinois Department of Public Health and law enforcement of the allegation of physical abuse.

On 11/03/2011 the surveyor confirmed through interview, observation, and record review that the facility took the following actions to remove the Immediate Jeopardy.

. R4 has been monitored and there has been no decline, and no adverse behaviors have been witnessed.

. E7 (Certified Nurse Aide) is no longer in the building or employed since 9/02/2011.

. On 11/03/2011 E1 (Administrator), and E2 (Director of Nurses) was in-serviced by the Petersen Health Care Regional Director on a revised Abuse Policy for the facility, reporting requirements, and consequences of not following the procedure and reporting requirements for potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of

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resident property.

. On 11/03/2011 E1 and E2 implemented the revised Internal Reporting Requirements and Identification of Allegations of the Abuse Policy for the facility 11/03/2011.

. On 11/03/2011 employees on duty were educated to immediately notify the Administrator of "any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect" by E2 and E3 (Assistant Director of Nurses).

. On 11/03/2011 employees on duty were educated of the consequences of not reporting potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator on by E2 and E3.

. On 11/03/2011 employees on duty were educated by reviewing the "Abuse Policy" identification of suspected abuse allegations, need to immediately remove the employee, family member, or visitor from the facility pending the outcome of the investigation, definition and identification of suspected abuse.

. On 11/03/2011 staff was not allowed to start their work shift on 2:00 pm - 10:00 pm or 10:00 pm - 7:00 am shifts at the facility until they have been in-serviced on the above and signing off saying they have been advised what will happen if they do not notify the administrator of potential/alleged mistreatment, neglect, and

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abuse of residents and misappropriation of resident property in which they observe, hear about, or suspect according to the Abuse Policy dated 11/-2/2011.

. Starting 11/03/2011 staff was not allowed to work without receiving an in-service on the revised Abuse Policy dated 11/03/2011 to immediately notify the Administrator of "any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect", the consequences of not reporting potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator, and upon identification of suspected abuse allegations, the need to immediately remove the employee, family member, or visitor from the facility pending the outcome of the investigation, definition, and identification of suspected abuse.

. On 11/03/2011 E1 posted the Administrator's contact information in the facility at different locations throughout the facility.

. E1 or designee will meet with each new hire and review the facility's Abuse Policy and reporting requirements and the consequences for not following the abuse policy.

. Starting 11/03/2011 E1 and/or E2 is to immediately notify the Regional Director on any incident that involves potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property to

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F 225	Continued From page 19 ensure compliance with F225 and F226. . To ensure the facility completes a thorough investigation the staff on duty at the time of administrator notification will be informed to make a note of visitors in the facility and which residents were in close proximately at the time of the incident which will be included in the investigation as well as the staff on duty the previous 24 hours prior to the reported incident. Staff members assigned to complete the investigation will write down the questions asked as well as the responses of the staff member and have the staff member sign the responses and make any needed revisions to the statements. The initial report will be completed by the staff member making the report, visitor, or resident if able. E1 and the Regional Director will review the investigations completed for thoroughness. . For Quality Assurance measures: E1 will ask random employees monthly what they would do if they witnessed, heard about, or suspected abuse of a resident or misappropriation of a resident's property, and correct any incorrect responses immediately and report in the Quarterly QA meeting. Weekly skin checks will be completed and monitored against reported skin reports.The data collected will be presented at the Quarterly QA committee for recommended improvements. E1 will review all abuse investigations on an ongoing basis to make sure they are completed thoroughly and timely.	F 225		

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F 225	Continued From page 20 In consult with the Corporate Regional Director a complete review of the Abuse Prevention Program, Policy and Procedure has been completed. Both E1 and E2 have been counseled on reporting any and all alleged allegations to Public Health within a timely manner which will not exceed 24 hours. This means that if it happens on a weekend it will be the responsibility of E1 or E2 to come to the facility to investigate, notify the Regional Director and report to Illinois Department of Public Health.	F 225		
F 226 SS=L	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop and/or implement policies and procedures that address notification of allegations of physical abuse within the required time frames to the Administrator, the Illinois Department of Public Health (IDPH), and law enforcement. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 11/03/2011 when the facility staff terminated the employment of E7, staff received training on immediate notification to the Administrator of any occurrences of potential/alleged mistreatment, neglect, and abuse of residents, and the consequences of not reporting, implemented and revised the Abuse Prevention Program and	F 226		11/22/11

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provided in-service on identification of allegations of abuse, the facility remains out of compliance at a level that is not actual harm with the potential for more than minimal harm due to revisions and additions of the Quality Assurance measures that require monitoring and follow-up.

Findings include:

R4 is a 92 year old woman who has resided in the facility since 6/3/2008 according to her admission record. The facility diagnoses sheet updated 5/7/2011 lists her diagnoses as follows:Chronic Anemia, Congestive Heart Failure, Kidney Disease, Hypertension, Dementia, ORIF left Hip with Trocho-nail, and Chronic Bilateral Lower Extremity Edema.

The most recent Minimum Data Set for R4 is a quarterly assessment dated 10/25/2011 and indicates minimal difficulty hearing, visual impairment, BIMS (Brief Interview for Mental Status) summary score is 99 indicating R4 was unable to complete the interview, long and short term memory problems, and moderately impaired cognitive skills for daily decision making. R4 requires 1 or more staff assistance for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. R4 is incontinent of bowel and bladder. R4 is ambulatory per wheelchair. The Behavioral Symptoms section of the Minimum Data Set of 10/25/2011 notes physical behavior symptoms directed toward others and verbal behavioral symptoms directed toward others which occurred 1 to 3 days of this assessment. The Care Plan for R4 dated 8/5/2011 includes a concern that R4 have fewer episodes of resistive or combative behavior

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F 226	Continued From page 22 during A.M. (morning) care. A review on 10/26/2011 of the facility's Abuse Prevention Program notes that the program does not address immediate notification to the administrator by staff other than supervisors. The Abuse Prevention Program does not address Section 1150 B of the Social Security Act that became effective on 3/23/2011. Section 1150 B establishes two time limits for the reporting of reasonable suspicion of a crime. The first is a 2 hour notification if the events "that cause the reasonable suspicion result in serious bodily injury to a resident", and the second is within 24 hours if the events "that cause the reasonable suspicion do not result in serious bodily injury to a resident." Notification to the police of reasonable suspicion of a crime was required using either time frame established in Section 1150 B of the Act. A review on 10/26/2011 of the facility's Abuse Prevention Program notes the facility did not follow Section IV Internal Reporting Requirements "supervisors shall immediately inform the Administrator or designated representative of all reports of potential mistreatment, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the Administrator or designee shall initiate an incident investigation." On 10/26/2011 at 10:00 am E1 (Administrator), was interviewed about an allegation of physical abuse involving R4 which occurred on 8/27/2011. When E1 was asked when she received notice of the allegation, she responded "I found out on Monday 8/29/2011 when E2 (Director of Nurses)	F 226		

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called me at home." E1 stated that she was not notified immediately, E1 stated that facility staff did not call the police at any time during the investigation, E1 also stated that notification of the incident was sent to IDPH on 9/2/2011 the date the Investigation of Possible Neglect/Abuse report was completed.

On 10/26/2011 at 10:45 am E2 (Director of Nurses) was interviewed regarding the allegation of physical abuse with R4 which occurred on 8/27/2011. E2 was asked when did she receive notice of the bruising to R4's face, E2 replied "on Monday morning 8/29/2011 when I was asked if I had seen the bruising to R4's face, I don't remember who made me aware of the bruise."

On 10/26/2011 at 10:25 am E3 (Assistant Director of Nurses) was interviewed regarding the allegation of physical abuse involving R4 on 8/27/2011, E3 was asked when did she receive notice of the allegation of 8/27/2011, E3 said "Monday morning 8/29/2011 when I heard staff talking about bruising to R4's face.

A review on 10/26/2011 of R4's nurses's note dated 8/27/2011 of notification of the skin tear to R4's hand to E2 (Director of Nurses), Z1 (Physician) and Z2 (Power of Attorney). Telephone interviews were conducted on 11/04/2011 at 1:20 pm with Z1 (Physician) and Z2 (POA), both parties acknowledged notification of an injury to R4 but neither party could confirm the date, cause or nature of the injury. Z1 stated "I can't remember that far back but I am sure they called me, they call me about everything."

A report of Investigation of Possible

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Neglect/Abuse dated 9/2/2011 was received by facsimile and recorded at the Regional Office of the Illinois Department of Public Health (IDPH) on 9/6/2011. This report documents that the facility investigated an allegation of verbal and physical abuse involving R4, a 92 year old resident, and a staff person E7 (Certified Nurse Aide) , on Saturday morning 8/27/2011. This report documents that E2 (Director of Nurses) received notification of a skin tear to the hand of R4 on the morning of 8/27/2011. This report documents that the source of the complaint is resident observation, and that an investigation was started on 8/29/2011.

A review of the Department's Incident Report file on 11/11/2011 noted The Marion Regional Office of the Illinois Department of Public Health (IDPH) did not receive from the facility an incident report involving R4 of an allegation of physical abuse occurring Saturday morning 8/27/2011.

A review on 10/26/2011 of the facility's Abuse Prevention Program noted the facility did not follow Section VII (1) (4) External Reporting of Potential Abuse. According to subsection (1) Initial Reporting of Allegations, if during the course of an incident investigation the administrator or designee has determined that there is reasonable cause to suspect mistreatment has occurred the resident's representative and the Department of Public Health shall be informed within 24 hours. Public Health shall be informed that an occurrence of potential mistreatment has been reported and is being investigated.

The facility also did not follow Subsection (4)

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Informing Law Enforcement Authorities. Subsection (4) states if there is clear evidence of abuse by an employee, the Department of Public Health will notify the Nurse Aide Registry or the Department of Professional Regulation. The Department of Public Health will also notify the State Police for further investigation of the employee. Depending on the seriousness of the incident and the presenting evidence the Administrator may also notify the local police. Subsection (4) as written negates the stated purpose and intent of the reporting regulation and relieves the facility of its duties, obligations and responsibilities of reporting. This subsection as currently stated places the facility's responsibility of reporting to the proper authorities onto The Department of Public Health. The Department of Public Health does not act as the reporting agency for facilities.

The Facility Data Sheet form completed by E1 (Administrator) on 10/25/2011 documents that the facility census was 52.

The Immediate Jeopardy was identified on 11/03/2011 at 11:00 am, E1 (Administrator), E2 (Director of Nurses), and E3 (Assistant Director of Nurses) were notified at that time. The Immediate Jeopardy was determined to have begun on 8/27/2011 when the facility failed operationalize effective abuse prohibition policies and procedures after R4 was physically abused by E7.

The surveyor confirmed through interview, observation, and record review that on 11/03/2011 the facility took the following actions to remove the Immediate Jeopardy;

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. R4 has been monitored and there has been no decline, and no adverse behaviors have been witnessed.

. E7 (Certified Nurse Aide) is no longer working in the building or employed at the facility since 9/02/2011.

. On 11/03/2011 E1 (Administrator), and E2 (Director of Nurses) was in-serviced by the Petersen Health Care Regional Director on a revised Abuse Policy for the facility, reporting requirements, and consequences of not following the procedure and reporting requirements for potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property.

. On 11/03/2011 E1 and E2 implemented the revised Internal Reporting Requirements and Identification of Allegations of the Abuse Policy for the facility 11/03/2011.

. On 11/03/2011 employees on duty were educated to immediately notify the Administrator of "any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect" by E2 and E3(Assistant Director of Nurses).

. On 11/03/2011 employees on duty were educated of the consequences of not reporting potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator on

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F 226	Continued From page 27 by E2 and E3.	F 226		

. On 11/03/2011 employees on duty were educated by reviewing the "Abuse Policy"
identification of suspected abuse allegations, need to immediately remove the employee, family member, or visitor from the facility pending the outcome of the investigation, definition and identification of suspected abuse.

. On 11/03/2011 staff was not allowed to start their work shift on 2:00 pm - 10:00 pm or 10:00 pm - 7:00 am shifts at the facility until they have been in-serviced on the above and signing off saying they have been advised what will happen if they do not notify the administrator of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property in which they observe, hear about, or suspect according to the Abuse Policy dated 11/02/2011.

. Starting 11/03/2011 staff was not allowed to work without receiving an in-service on the revised Abuse Policy dated 11/03/2011 to immediately notify the Administrator of "any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect", the consequences of not reporting potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator, and upon identification of suspected abuse allegations, the need to immediately remove the employee, family member, or visitor from the facility pending the

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F 226	Continued From page 28 outcome of the investigation, definition, and identification of suspected abuse. . On 11/03/2011 E1 posted the Administrator's contact information in the facility at different locations throughout the facility. . E1 or designee will meet with each new hire and review the facility's Abuse Policy and reporting requirements and the consequences for not following the abuse policy. . Starting 11/03/2011 E1 and/or E2 is to immediately notify the Regional Director on any incident that involves potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property to ensure compliance with F225 and F226. . To ensure the facility completes a thorough investigation the staff on duty at the time of administrator notification will be informed to make a note of visitors in the facility and which residents were in close proximately at the time of the incident which will be included in the investigation as well as the staff on duty the previous 24 hours prior to the reported incident. Staff members assigned to complete the investigation will write down the questions asked as well as the responses of the staff member and have the staff member sign the responses and make any needed revisions to the statements. The initial report will be completed by the staff member making the report, visitor, or resident if able. E1 and the Regional Director will review the investigations completed for thoroughness.	F 226		

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F 226	Continued From page 29 . For Quality Assurance measures: E1 will ask random employees monthly what they would do if they witnessed, heard about, or suspected abuse of a resident or misappropriation of a resident's property, and correct any incorrect responses immediately and report in the Quarterly QA meeting. Weekly skin checks will be completed and monitored against reported skin reports.The data collected will be presented at the Quarterly QA committee for recommended improvements. E1 will review all abuse investigations on an ongoing basis to make sure they are completed thoroughly and timely. In consult with the Corporate Regional Director a complete review of the Abuse Prevention Program, Policy and Procedure has been completed. Both E1 and E2 have been counseled on reporting any and all alleged allegations to Public Health within a timely manner which will not exceed 24 hours. This means that if it happens on a weekend it will be the responsibility of E1 or E2 to come to the facility to investigate, notify the Regional Director and report to Illinois Department of Public Health.	F 226		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253		11/22/11

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F 253	Continued From page 30 by: Based on observations and interview, the facility failed to ensure that the beginning of 200 hall in the facility does not have strong odors. This has the potential to affect all 24 residents (R5 - R7, R10, R15 - R34) living on 200 hall. The findings include: During the initial tour of the facility on 11-02-11 at 9:40 am, strong pervasive odors were detected in the beginning third of 200 hall. This is where the 2 common rest rooms are located. During the environmental tour of the facility on 11-03-11 at 11 am, odors were still present in this area and were strongest in the two common restrooms which have vinyl tile floors. Odors were also noted the mornings of 11-04-11 and 11-08-11. This information was discussed with E1, Administrator on 11-14-11 at 3 pm. The daily roster dated 11-2-11 indicates there are 24 residents (R5 - R7, R10, R15 - R34) residing on the 200 hall of the facility.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		11/22/11

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F 272	Continued From page 31 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents with personal enabler devices are completely and accurately assessed for the need for the device and that the individual assessments are specific to each resident for 4 of 14 residents. (R5, R8, R10, R11) reviewed for personal enabler devices in the sample of 14.	F 272		

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F 272	Continued From page 32 Findings Include: 1. During observations on 11/02/11 at 1:25 p.m., 11/03/11 at 1:00 p.m. and 11/08/11 at 12:20 p.m., R8 was observed sitting in her wheelchair in the Dining Room. R8 was slumped forward and had a alarm attached from the back of her blouse to the back of the wheelchair. Per interview with E10 (Activity Director) on 11/02/11 at 1:30 p.m., E10 said that R8's chair alarm is on her at all times when she is in her wheelchair. On 11/03/11 during review of R8's care plan regarding the potential for falls, there was no documentation regarding the use of a personal body alarm. There was also no assessment to determine the need for the personal body alarm. During review of R8's "Physical Restraint Assessment 2" dated 11/06/11, documentation states that R8 requires a personal body alarm while in wheelchair due to poor posture and poor safety awareness. Continued documentation on this assessment states, "Assessment must be completed prior to Restraint Application." Upon review of the facility's "Safety Assessment" dated 11/06/11, documentation states that R8 requires a chair alarm due to a diagnosis of seizures and poor posture while in the wheelchair. 2. R5's November, 2011, physician's order sheet documents that he has safety device orders for self release seatbelt for safety/positioning. On	F 272		

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11-02-11 at 12:35 pm, R5 was observed eating lunch. At that time he had a body alarm attached to his wheelchair and the back of his shirt.

The facility physical restraint/enabler assessment did not specify what devices were assessed until this was brought to the attention of E3, Assistant Director of Nurses on 11-03-11 at 1:30 pm. E3 stated and then wrote on the assessment "For Seat belt and Low bed". The only less restrictive alternatives given were commode at bedside, regular timed toileting, verbal cueing, and call light answered promptly. The benefits and risks given on this assessment relate to turning and positioning and climbing over which are not benefits and risks when using a seat belt or a low bed.

The facility physical restraint elimination assessment last updated on 09-15-11 documents that R5 is a good candidate for reduction and elimination. There is no plan in place to reduce the seat belt on R5's care plan dated 08-16-11.

There was no assessment of the body alarm used by R5 when he is in bed or in his wheel chair. This was verified by E3 on 11-03-11 at 1:30 pm.

3. R11's November, 2011, physician's order sheet documents that she has safety device orders for a padded lap device. The facility physical restraint/enabler assessments dated 6-1-11 and 10-25-11 does not specify what device or devices were assessed on these forms. The risks verse benefits given on these forms entrapment, isolation, and increased mobility while in bed. These are not benefits and risks for

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F 272	Continued From page 34 the use of the padded lap device. There is also no plan in place to reduce the padded lap device. This information was verified by E3 on 11-03-11 at 1:30 pm. 4. R10's November 2011 physician order sheet indicates that R10 uses full side rails for fall prevention and bed mobility .The Physical Restraint/Enabler Assessment is undated and is noted to list the use of a personal body alarm on page 1 and both the personal body alarm and full side rails on page 2. The assessment does not address the risks versus benefits of full side rail use and does not include information found on the care plan of 9-11-11 that indicates that R10 likes to hang her legs off of bed .In addition, the incident of 9-19-11 where R10 was found in the floor, shortly after being put to bed with full side rails in use, was not utilized on the assessment.	F 272		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to provide restorative programming for maintenance of mobility for 1 (R9) of 5 residents reviewed for restorative programming from the sample of 14. Findings include:	F 311		11/22/11

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1. R9 is an 84 year old resident with diagnoses that include Nerve Palsy, Obesity and Dementia as noted on the Cumulative Diagnosis Sheet. R9 was observed sitting up in a straight back wheeled chair at the noon meal on 11-4-11. At 1:40 pm R9 was observed to be pushed down the hall to his room. E5 and E6, Certified Nurse Aides, were observed to transfer R9 from his chair to his bed using a mechanical lift device which required R9 to be able to support the majority of his own weight. R9 did not appear able to support the majority of his weight during the transfer and was heard to repeatedly say, "Oh! Oh!". R9 was observed to be hanging from the sling under his arms.

A Therapy Discharge Note dated 5/25/11 indicated that at the time that R9 was discharged from therapy it was with 'goals partially met'. The note indicated that R9 was discharged to restorative programming for bed mobility and transfers and indicated that staff were to use a mechanical lift device for transfers. The 'evaluation to discharge' indicated that R9 had achieved 'moderate assist of 2' for sit to stand transfer and 'moderate assist of 2 and lift' for pivot transfer. The observation made on 11-4-11 of R9 in the lift indicated that there had been a decline in R9's ability to be transferred using this particular lift device.

A Comprehensive Nursing Assessment dated 5-26-11 and signed as completed by E2, Director of Nurses, indicates that based on R9's uncooperative and resistive behaviors as well as cognition, he was considered a poor candidate for restorative programming and the transfer and bed mobility programs were discontinued.

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F 311	Continued From page 36 The restorative programming list provided by the facility during this survey did not include R9 as being in a restorative program. There was no indication in the record that R9 had received any restorative programming since being discontinued from skilled physical therapy. This was verified by E2, Director of Nurses, on 11-8-11 at 3:00 pm.	F 311		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observation, record review and interview the facility failed to ensure that residents at risk for falls are adequately assessed, failed to implement appropriate interventions and fall prevention measures, and failed to provide necessary assistance and monitoring to prevent falls for 2 of 14 residents (R4 and R13) reviewed for falls in the sample of 14. These failures resulted in R4 sustaining a fractured hip 5/3/2011 requiring hospitalization and surgery to repair the fracture. Findings include: 1. R4 is a 92 year old woman residing in this	F 323		11/22/11

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facility since 6/30/2008 according to facility admission records. The Physician Order Sheet lists R4's diagnoses to include Chronic Anemia, Congestive Heart Failure, Osteoarthritis, Chronic Kidney Disease, Hypertension, Dementia, and ORIF Post Left Hip Fracture. A review on 10/26/2011 of R4's record finds documentation of fall history. Nurse's notes show R4 fell on 3/12/2011 and was found in a peer's room on her knees at the foot of the bed, intervention to monitor location and keep in a common area. On 4/17/2011 R4 fell out of bed injurying her right shoulder, right shoulder blade and right hip, intervention 1/2 side rails for bed mobility and stabilization when rising. Following the falls of 3/12/2011 and 4/17/2011 no other interventions were put in place.
R14 continued to fall, further review of the nurses notes show the following;

On 5/03/2011 R4 was found on floor in room, she was incontinent. This fall resulted in R4 sustaining a fractured hip requiring hospitalization and surgery to repair the fracture, intervention utliized upon return to the facility included PT/OT evaluation and treatment, and to reinforce toileting. On 6/23/2011 R4 fell again, this fall occurred in the dining room, R4 was noted to be restless and confused, interventions were added for fall prevention to distract and occupy time with activities, toilet every 2 hours and when restless. On 7/1/2011 R4 was attempting to transfer self with near fall, new order received for self releasing Velcro seat belt. On 7/9/2011 R4 fell again while in hallway wandering, 15 minute visual checks x 48 hours until evaluated by IDT was added. On 7/10/2011 R4 continued to have falls and was found on floor in room,

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Complaining of pain to her left hip, leg, and knee R4 was transferred to the local hospital for evaluation. On 7/11/2011 following this fall the facility added seatbelt and low bed to the interventions. On 9/25/2011 R4 was found sitting on floor next to low bed and sustained 2 areas of purple discolorations to left forearm with this fall.

Care plan dated 5/9/2011 notes R4 to be at risk for falls due to fractured hip, unaware of physical restrictions, unsteady gait, and attempting to walk without walker. This care plan identifies the use of bed alarm to remind R4 of safety issues. Physical Restraint/Enabler Assessment (not dated) notes 1/2 side rails 4/18/2011, low bed with side rails 7/10/2011, and self releasing seatbelt with alarm 7/11/2011. The Cognitive Assessment dated 8/5/2011 notes a score of 3 indicating R4 is severely impaired.

According to the Minimum Data Set dated 10/25/2011, Section P Restraint, siderails are not being used for R4 but a trunk restraint is used daily. Observation on 10/25, and 10/26/2011 at 9:00 am found R4 sitting in the dining room in a wheelchair. On both days it was observed that a chair alarm, body alarm and seatbelt (not self releasing) was being used for R4. Observation of R4's bedroom on 10/25/2011 and 10/26/2011 at 9:15 am observed that there were no 1/2 siderails present and a low bed was being used. During an interview on 10/26/2011 at 12:00 pm with E14 (Registered Nurse), when asked about the non releasing seatbelt being used for R4, E14 stated "she kept taking the self releasing one off."

2. R13 a 91 year old man residing in this facility since 8/26/11 according facility admission

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records. The Physician Order Sheets dated 9/1/2011 lists R13's diagnoses to include; Cellulitis, Anemia, Congestive Heart Failure, Bone Marrow Failure and Euthyroid Sick. A review on 11/02/2011 of R13's record finds admission nurses note dated 8/26/2011 documenting R13 has a history of climbing out of bed and wandering, alert and oriented to self, confused, resistive to care, uncooperative, aggressive to staff and other residents, attempts to get up without assistance, incontinent, mobile per wheelchair and can self propel.

Care plan dated 9/12/2011 notes R13 has risk factors that require monitoring and intervention to reduce potential for injury including unsteady/unsafe transfer or ambulation. Fall Risk Assessment dated 9/1/2011 score is 21(high risk). The Side Rail Consent dated 8/26/2011 is incomplete. The Side Rail Assessment dated 9/3/2011 identified the need for 1/2 siderails for enabler, transfers, and positioning. The Minimal Data Set dated 9/9/2011 notes BIMS score of 3 out of 15, and the Care Area Assessment for falls indicate R13 is increased risk for falls due to generalized weakness, and decreased cognitive awareness and R13 has 1/2 siderails and personal body alarm related to his falls.

A review on 11/02/2011 of nurses notes for accidents/incidents for R13 identify 5 falls from 9/1/2011 thru 10/7/2011. On 9/1/11 R13 was found on floor in his room, stated staff pushed him down, 9/22/11 found on floor by maintenance man, 10/1/11 found on floor in front of bedside commode, 10/4/2011 found on floor in front of bedside commode after being left unattended, 10/7/11 found on floor by bedside commode.

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This review finds nurses notes on 9/27/2011 of R13 having a bed alarm, a reclining chair with feet elevated preventing R13 from getting up without assistance on 9/5, 9/13, 9/14 and 9/18/2011, a personal body alarm 8/26/2011, and chair alarm 9/15/2011. Further review of R13's record fails to find documentation of assessments for the use of the bed alarm, chair alarm, personal body alarm, or reclining chair or whether these interventions were appropriate for R13. There is no documentation of post fall review for the falls of 9/22, 10/1, 10/4, or 10/7/2011. There are also nurses notes in the record 9/5, 9/11, 9/17, 9/21, and 10/7/2011 of R13 removing the alarms, and a nurses note dated 10/8/2011 stating R13 continues to get up without assistance.

During an interview at 2:00 pm with E14 (Registered Nurse) about the use of the reclining chair with the legs elevated to prevent R13 from getting up E14 stated " sometimes that was the only way we could keep up with him and he usually went to sleep, no it was not being used as a restraint but to keep him from falling." No observations were made during this survey as R13 was discharged from this facility and admitted to the Illinois Veterans Home on 10/11/2011.

B. Based on observation, interview, and record review, the facility failed to provide a safe environment during eating and transfers, and failed to comprehensively assess side rails use for 3 of 14 residents (R7, R9, and R10) reviewed for safety issues in the sample of 14.

1. On 11-4-11 at 10:55 am R10 was observed

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laying her bed with full side rails in the up position on both sides of the bed. Incontinence care was being provided by staff and R10 was turned by staff. R10 did not utilize either of the rails to assist in turning.

The current physician order sheet for 11-2011 indicates that full side rails x 2 are used for fall prevention and bed mobility. A 9-19-11 fall investigation report indicated that at 7:30 pm, R10 was found in the floor beside her bed, laying on her right side, shortly after having been put in bed. The report indicated that full rails were in use at the time. The new intervention to prevent another fall was '15 minute checks started.'

R10's current care plan dated 9-11-11 indicates under potential for skin breakdown and potential for falls that R10 "likes to hang her legs off of bed". One of the approaches listed under each of these areas is full side rails x 2. R10 is assessed as high risk for falls on the 9-19-11 fall risk assessment. The facility has not assessed the use of these full rails as a safety hazard for R10.

2. R9 was observed on 11-4-11 at 1:40 pm being transferred with the use of a mechanical device to aide with standing and transferring. E5, Certified Nurses Aide, was observed at the front of the device and E6, Certified Nurses Aide, was observed helping R9 put his hand on the hand holds and his feet flat on the platform of the mechanical device. The blue material sling was bunched up around him and was positioned under his arms. The mechanical device was used to raise R9 up out of his wheel chair. During this lift, R9 was not supporting his weight and was heard to repeatedly say, "Oh! Oh!". R9

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F 323	Continued From page 42 was observed to be hanging from the sling under his arms. Review of the manufacturers guidelines for using this mechanical device documents that for the standing sling, "Individuals that use the standing sling must be able to support the majority of their own weight, otherwise injury can occur. Before lifting the patient, make sure the bottom edge of the standing sling is positioned on the lower back of the patient and the patient's arms are outside the standing sling." 3. Review of R7's nurse's notes dated 10-05-11 with no time given documents "Resident accidently spilled bowl of ham and beans on R7's (right) thigh. This nurse went to assess & found 3 blisters had formed....N.O. (new order) received for Silvadene topical ointment to blistered area daily until healed related to burn." The October, 2011, wound sheet documents that the size on 10-06-11 was 1.5 by 2 cm., on 10-14-11 was 5.1 by 6 cm, 10-21-11 was 9 by 6 cm, and on 10-28-11 was 3.5 by 3 cm. R7 was interviewed on 11-02-11 at 1:30 pm and stated that she did accidently spill a bowl of ham and beans on her right thigh. R7 said that she eats in her room in bed with the food sitting on her chest. According to R7, she had on a medium thickness t-shirt and a cloth napkin under her dish or plate. R7 also stated that the beans were very hot and it hurt a lot when it happened. There is no assessment of this incident nor a plan in place to prevent this from happening again. This was verified by E2 on 11-04-11 at 1 pm.	F 323		
F 458	483.70(d)(1)(ii) BEDROOMS MEASURE AT	F 458		11/22/11

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F 458 SS=B	Continued From page 43 LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide at least 80 square feet of floor space per resident bed in 29 multiple resident rooms in the facility. This has the potential to affect 10 of 14 residents (R1, R2, R4- R10, & R12) in the sample and 35 of 35 residents (R15 - R49) in the supplemental sample. The findings include: 1. Multiple resident rooms 200 through 214 and 301 through 314 only provide 75 square feet of floor space per resident bed instead of the required 80 square feet of floor space. These rooms are all provided with two beds each and are all Medicaid certified. According to the facility daily roster, these rooms are occupied by R1, R2, R4 - R10, R12, R15 through R49. At the time of the survey, the space provided in these rooms was observed to be adequate to meet the needs of the residents. This was discussed with E1, Administrator, during the daily status meeting on 11-04-11 at 9:30 am.	F 458		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		11/22/11

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F 514	Continued From page 44 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to maintain accurately documented, complete, and legible resident records for 1 of 14 residents (R4)whose record was reviewed for accuracy, legibility and completeness in the sample of 14. Findings include: R4 is a 92 year old woman residing in this facility since 6/30/2008 according to facility admission records. The Physician Order Sheet lists R4's diagnoses to include Chronic Anemia, Congestive Heart Failure, Osteoarthritis, Chronic Kidney Disease, Hypertension, Dementia, and ORIF Post Left Hip Fracture. On 8/27/2011 R4 was involved in an incident that resulted in injuries to right arms, left hands, face, and head, as verified per interview with E4 (Certified Nurse Aide) on 10-26-11 and E8 (Certified Nurse Aide) on 11-02-11. A review on 10/25/2011 of R4's record	F 514		

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found a nurse's notes dated 8/31/2011 " noted bruising on facial area appears to have spread" and a nurse's note dated 9/3/2011 (late note) "noted discoloration on resident's face on 8/29/2011." No other documentation was found that addresses the bruising/discoloration to R4's face. This record review fails to find documentation of an assessment for possible injuries to R4's head (hair pulled out), no documentation of healing or lack of healing to the skin tears on the right arm and left hand, no documentation of R4's response to treatment of injuries, no documentation of any mental or psychological effect this incident might have had on R4, no documentation of preventative measures being utilized to prevent R4 from other occurrences.

A written notation on the care plan dated 8/31/2011 "when showing or having aggressive behaviors walk away, monitor from a distance, re attempt with care at a later time, do 1:1 as needed" This care plan fails to address care and treatment for injuries R4 received during the incident of 8/27/2011.

During an interview on 10/26/2011 at 11:00 am with E3 (Assistant Director of Nurses), when asked about the lack of documentation in the record for R4 of the incident of 8/27/2011, E3 did not provide an answer but stated "I will look and see if there are more notes that are not in the record." Shortly thereafter E3 returned with additional nurse's notes for 05/03/2011 thru 10/01/2011 for R4's record In the additional notes provided by E3 were no additional notes that addressed the incident and injuries of 8/27/2011. E3 was again asked if what she had

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F 514	Continued From page 46 provided was all the documentation for R4's record and E3 answered "yes". Further review of R4's record finds R4's record void of nurse's notes from 5/3/2011 thru 7/3/2011.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.690b) 300.690c)c) 300.695b)1) 300.3240a) 300.3240b) 300.3240d) 300.3240e) 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 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. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this	F9999		

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F9999	Continued From page 47 Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor; Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)	F9999		

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e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These requirements are not met as evidenced by:

Based on record review and interviews, the facility failed to ensure that residents are kept free from physical abuse for 1 of 14 residents (R4) reviewed for physical abuse in the sample of 14. This failure resulted in R4 sustaining skin tears to hands and arms, black eyes, and bruising to the face.

Findings include:

1. R4 is a 92 year old woman who has resided in the facility since 6/3/2008 according to her admission record. The facility diagnoses sheet updated 5/7/2011 lists her diagnoses as follows: Chronic Anemia, Congestive Heart Failure, Kidney Disease, Hypertension, Dementia, ORIF left Hip with Trocho-nail, and Chronic Bilateral Lower Extremity Edema.

The most recent Minimum Data Set for R4 is a quarterly assessment dated 10/25/2011 and indicates minimal difficulty hearing, visual impairment, BIMS (Brief Interview for Mental Status) summary score of 99 indicating R4 was

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unable to complete the interview, long and short term memory problems, and moderately impaired cognitive skills for daily decision making. R4 required 1 or more staff assistance for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. R4 was incontinent of bowel and bladder. R4 was ambulatory per wheelchair. The Behavioral Symptoms section of the Minimum Data Set of 10/25/2011 notes physical behavior symptoms directed toward others and verbal behavioral symptoms directed toward others which occurred 1 to 3 days of the assessment. The Care Plan for R4 dated 8/5/2011 includes a concern that R4 have fewer episodes of resistive or combative behavior during A.M. (morning) care.

On 8/29/2011 the facility filed a report with the Illinois Department of Public Health of an Investigation of Possible Neglect/Abuse of an incident on 8/27/2011 involving R4. The report notes on 8/27/2011 during morning care R4 sustained a skin tear to her hand, and on 8/29/2011 R4 was noticed to have faint discoloration on the right side of her face. During this investigation the facility notes that multiple staff interviews were conducted and two Certified Nurse Aides E4 and E8 present during the incident stated that E7 the third Certified Nurse Aide was "too rough" while trying to assist R4 getting dressed. E7 stated she felt the skin tear was caused by her watch.

On 8/27/2011 E7 (Certified Nurse Aide) provided the facility a written statement of the incident. In this statement E7 writes R4 was "resistive to care when we were cleaning her up from having a bowel movement and she was grabbing my arms,

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biting me, and grabbing my clothes, it was then that we noticed the skin tears to her hands and arms. We notified E11 (Registered Nurse) and she bandaged it up." No written statements were obtained from other staff on 8/27/2011.

On 8/29/2011 E2 (Director of Nurses) initiated further inquiry into this incident. On 8/29/2011 E7 (Certified Nurse Aide) was interviewed at the facility by E2 and provided details of the incident. In this interview E7 states R4 "had a bowel movement and we were trying to clean her up, she was scratching and fighting." E7 identifies E4 and E8 (Certified Nurse Aides) as two other staff persons in attendance during this incident. E7 continues the interview by stating R4 was flailing her arms around and "I think it was my watch that cut her hand." E7 adds that" there was no bruise or redness on the right side of R4's face at this time."

On 8/29/2011 at the facility E2 (Director of Nurses) interviewed E4 (Certified Nurse Aide) of the incident on 8/27/2011 involving R4. E4 wrote in the statement that R4 "had a bowel movement and we were trying to clean her up." E4 identified E7 and E8 (Certified Nurses Aides) as also being present during this incident. E4 stated that E7 was arguing with R4 and was swearing calling R4 a "bitch" and E7 pulled R4's hair. In conclusion of this statement, E4 writes "it is my observation that E7 is argumentative with residents, swears at them, and is too rough."

On 8/29/2011 at the facility E2 (Director of Nurses) interviewed E8 (Certified Nurse Aide) of the incident on 8/27/2011 involving R4. E8's written statement notes "E7 (Certified Nurse

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Aide) was grabbing R4 too rough, she also called R4 an "old bitch" and was pulling her hair.

On 8/30/2011 at the facility E2 (Director of Nurses) interviewed E9 (Registered Nurse) about the incident on 8/27/2011 involving R4. E9 stated E4 and E7 (Certified Nurse Aides) "were dealing with R4 and R4 was trying to get up out of her chair and E7 was trying to put R4 back in the chair and grabbed her hair by accident."

On 8/30/2011 at the facility E2 (Director of Nurses) interviewed E11 (Registered Nurse) about the incident on 8/27/2011 involving R4. E11 stated E8 (Certified Nurse Aide) told her someone was needed in R4's room, R4 was combative and had a small skin tear on her forearm. E11 responded and noticed a large skin tear on the top of R4's left hand. E11 spoke with E7 (Certified Nurse Aide) who stated "her keys or her watch could have caused the skin tear." E11 talked to E4 (Certified Nurse Aide) and asked what happened, E4 (Certified Nurse Aide) stated she "did not know what E7 was doing but she did see E7 grab R4's hair. E11 again spoke with E7 about the incident and E7 stated "R4 was leaning forward and when E7 went to pull R4 back E7 accidentally grabbed R4's hair."

On 10/26/2011 at 8:50 am a telephone interview was conducted with E7 (Certified Nurse Aide) involving the incident on 8/27/2011 with R4. E7 was asked to provide a detailed statement of the events of the incident of 8/27/2011. E7 stated "Saturday morning 8/27/2011 around 6:30 am working with E4 and E8 (Certified Nurse Aides) we went to get R4 up for the morning. R4 was combative, pulling at us, scratching us, grabbing

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the under part of our arms. We were going to set her back down and try again later but she would not let us go so we put her in the wheelchair. R4 had a bowel movement and I sent E8 (a new girl) to go get washcloths and supplies so we could clean her up. I don't know how the skin tears happened. It was either because R4 has thin skin or by my watch." When we noticed the skin tears I sent E8 to get the nurse. When E7 was asked at anytime did she or any other staff person intentionally or unintentionally harm R4, E7 stated "no, I would never hurt one of these older people who cannot take care of themselves, I am here to help them." When asked what happened next, E7 stated I was asked to give a statement to the nurse E11 (Registered Nurse) and I did. I worked Saturday and Sunday. On Monday I was called to the facility and questioned by E2 (Director of Nurses) and E1 (Administrator), on Monday I was suspended and by Wednesday I was terminated. E7 was asked for what reason she was terminated and she said, "I was told I broke a rule but I believe it was because of what happened to R4." E7 stated she was told she had hit R4 with her fist and that R4 had massive bruises all over her face. E7 stated of the three staff working with E7 during the incident she was the only person terminated.

On 10/26/2011 at 9:15 am a telephone interview was conducted with E4 (Certified Nurse Aide) involving the incident on 8/27/2011 with R4. E4 was asked to provide a detailed statement of the events of the incident of 8/27/2011. E4 stated, "it was on a Saturday about 6-6:30 am at the beginning of the shift, I was working with E7 and E8 (Certified Nurse Aides), E8 was new still in orientation. We went to get R4 up, I believe out

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of fear of falling, R4 had broken her hip in May reached out for support and grabbed E7's arms digging her fingernails into E7's arms. E7 in return dug her fingernails into R4's arms scratching her. E7 was calling R4 names. E7 shook R4, pulled R4's hair so hard there was hair in E7's hand, and E7 slammed R4 down into the wheelchair. I yelled E7 'stop that you are hurting R4.' R4 was screaming, there was blood on R4's arms. E7 was out of control and not listening to me. E8 went and got the nurses E9 and E11(Registered Nurses), E9 and E11 took R4 into the bathroom and treated her arms. I immediately reported what happened on 8/27/2011 to E11 and E9. I worked a double shift on Saturday and Sunday. On Monday 8/30/2011 I was called into the office and questioned about the incident by both E1 (Administrator) and E2 (Director of Nurses) and I told them what happened. They said I did the right thing by reporting it, I did not get into trouble. I heard through hearing other staff talk that E7 was terminated because of what she did to R4. I don't know what happened to E8 (the new girl). She stopped working there soon after."

On 11/02/2011 at 1:55 pm a telephone interview was conducted with E8 (Certified Nurse Aide) involving the incident on 8/27/2011 with R4. E8 was asked to provide a detailed statement of the events of the 8/27/2011. E8 stated, "I had been working there only a couple of weeks and I was placed on a hall with E7 and E4 (Certified Nurse Aides). E7 was hollering at R4 and put her weight on R4 holding R4 down. R4 was trying to get up and screaming. E7 was roughing up on R4 and pushed R4 down in the chair. R4 needed to be cleaned up again so E7 and E4 told me to

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go get supplies to clean R4 up with. I left the room. When I returned to the room E4 was telling E7 to leave the room. E7 was too worked up. E7 had a handful of R4's hair. I saw her pull out R4's hair. I heard E7 call her "an old bitch," then I saw two big gashes on R4's hands. They told me to get a nurse. I did not see how R4's arm got injured. That same day 8/27/2011 I was questioned by E11 (Registered Nurse) as to what happened. E11 told me since I was new I didn't have to get involved and I didn't need to write a statement just tell her what happened and I did. E7 was fired due to abuse to R4. A few days later I noticed R4 had two black eyes and one side of her face was bruised. I was fired and the reason I was given was because of no call no show which was not true."

On 11/2/2011 at 2:30 pm in the social service office at the facility an interview was conducted with E9 (Registered Nurse) involving the incident on 8/27/2011 with R4. E9 was asked to provide a detailed statement of the events of 8/27/2011. "On 8/27/2011 R4 had a skin tear that morning, me and E11 (Registered Nurse) responded. E4, E8 and E7 (Certified Nurse Aides) were working in that room. I saw blood from a skin tear on R4's wrist. We took R4 into the bathroom on 100 hall because R4 was living on 100 hall at that time to clean it up. R4 was upset. I thought it was because of the skin tear or because too many people were around, that sometimes upsets R4. There was one skin tear on the back of her hand and a scratch possibly on one arm. I can't remember if we put anything on it or not. R4 was not my resident so E11 filled out the skin tear papers, incident report and questioned staff as to what happened." E8 was questioned and asked

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what happened. E8 said 'we were getting R4 up and R4 was resisting care, flailing her arms and hit her hand. R4 was falling out of the chair and E7 reached for R4 pulling her hair but not intentionally.'" When asked about bruises to R4's face E9 stated, "I knew nothing about this until E2 (Director of Nurses) asked me to come in an give a statement. It was then that I noticed the bruises, this was on Monday, I never noticed anything on Sunday." E9 was asked to describe the bruises to R4's face and E9 said "the bruises were on the right side in the cheek area, it was yellowish and it was large enough you could see it.".

On 11/03/2011 at 9:00 am E14 (Registered Nurse/Charge Nurse) was interviewed about bruises and black eyes on R4. E14 denied seeing or having knowledge at any time of R4 having bruises or black eyes.

On 11/03/2011 at 9:30 am E3 (Assistant Director of Nurses) was interviewed about bruises and black eyes on R4. E3 denied seeing or having knowledge of black eyes on R4 but stated in the right lateral eye area there was a faint yellow bruise that was visible when you looked at R4 head on.

On 10/26/2011 at 10:45 am in a designated work area at the facility E2 (Director of Nurses) was interviewed about skin tears and bruises on R4. E2 stated skin tears were evident on 8/27/2011 but there was no bruising to the face at this time. Around 8/29/2011 bruising was noted to the face, the bruise was faint, I don't remember what side it was on, seems like it started in the temple area and went to the cheek. On 11/03/2011 at 10:00

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am E2 was asked at any time did R4 have black eyes, E2 stated "yes, on 8/29/2011."

On 11/03/2011 at 1:20 pm in the social service office at the facility, E12 (Certified Nurse Aide) was interviewed about bruises and black eyes on R4. E12 stated "I was off on 8/27/2011 and 8/28/2011. I returned to work on Monday 8/29/2011 and R4 had a black right eye and bruises on her neck. On 8/30/2011 the bruising had spread across her face to both eyes and R4 looked like a little raccoon, that pissed me off that someone would hurt R4."

On 11/03/2011 at 1:40 pm in the social service office at the facility, E4 (Certified Nurse Aide) was again interviewed about the incident on 8/27/2011 with R4. During this interview E4 was asked what day, what time, and to whom did she report this incident. E4 stated "I reported it within a few minutes of it happening. I went to E9 and E11 (Registered Nurses) and asked to speak with them. We went into E2's (Director of Nurses) office to talk." What did you tell the nurses? " I said that I felt E7 (Certified Nurse Aide) was too rough and aggressive and what happened to R4 did not need to happen." E7 was asked where did the incident occur and E4 stated "it happened in R4's room on 100 hall." What did you tell the nurses happened? "I told them that E7 pulled R4 roughly to the side and tugged her back and forth, cursing her, calling her names. E7 had hold of R4's hair and was pulling it, and pulled it out. I told E7 that was enough as E7 had R4's feet off the ground. The skin tear to the back of R4's hand was directly due to E7's roughness. E7 tore the skin off. E9 and E11 thanked me and said they would tell E2 (Director of Nurses)."

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F9999	Continued From page 57 On 11/04/2011 at 10:10 am in the social service office at the facility, E11 (Registered Nurse) was interviewed about the incident on 8/27/2011 involving R4. E11 stated E7 (Certified Nurse Aide) told her someone was needed in R4's room. R4 was combative and had a small skin tear on her forearm. E11 responded and noticed a large skin tear on the top of R4's left hand. "I spoke with E7 who stated 'her keys or her watch could have caused the skin tear.' I talked to E4 (Certified Nurse Aide) and asked what happened. E4 stated she 'did not know what E7 was doing but she did see E7 grab R4's hair.' I again spoke with E7 about the incident and E7 stated 'R4 was leaning forward and when E7 went to pull R4 back E7 accidentally grabbed R4's hair.'" When asked about bruises to R4's face, E11 stated I saw the bruises that following Tuesday when I came into the facility to give a statement. The bruise was on the right cheek bone and it was yellow-green in color. I did not see R4 with black eyes. (A) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	F9999		

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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 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.
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, record review and interview the facility failed to ensure that residents at risk for falls are adequately assessed, failed to implement appropriate interventions and fall

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prevention measures, and failed to provide necessary assistance and monitoring to prevent falls for 2 of 14 residents (R4 and R13) reviewed for falls in the sample of 14. These failures resulted in R4 sustaining a fractured hip 5/3/2011 requiring hospitalization and surgery to repair the fracture.

Findings include:

1. R4 is a 92 year old woman residing in this facility since 6/30/2008 according to facility admission records. The Physician Order Sheet lists R4's diagnoses to include Chronic Anemia, Congestive Heart Failure, Osteoarthritis, Chronic Kidney Disease, Hypertension, Dementia, and ORIF Post Left Hip Fracture. A review on 10/26/2011 of R4's record finds documentation of fall history. Nurse's notes show R4 fell on 3/12/2011 and was found in a peer's room on her knees at the foot of the bed, intervention to monitor location and keep in a common area. On 4/17/2011 R4 fell out of bed injurying her right shoulder, right shoulder blade and right hip, intervention 1/2 side rails for bed mobility and stabilization when rising. Following the falls of 3/12/2011 and 4/17/2011 no other interventions were put in place.
R14 continued to fall, further review of the nurses notes show the following;

On 5/03/2011 R4 was found on floor in room, she was incontinent. This fall resulted in R4 sustaining a fractured hip requiring hospitalization and surgery to repair the fracture, intervention utliized upon return to the facility included PT/OT evaluation and treatment, and to reinforce toileting. On 6/23/2011 R4 fell again, this fall

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occurred in the dining room. R4 was noted to be restless and confused. Interventions were added for fall prevention to distract and occupy time with activities, toilet every 2 hours and when restless. On 7/1/2011 R4 was attempting to transfer self with near fall, new order received for self releasing Velcro seat belt. On 7/9/2011 R4 fell again while in hallway wandering, 15 minute visual checks x 48 hours until evaluated by IDT was added. On 7/10/2011 R4 continued to have falls and was found on floor in room complaining of pain to her left hip, leg, and knee. R4 was transferred to the local hospital for evaluation. On 7/11/2011 following this fall the facility added seatbelt and low bed to the interventions. On 9/25/2011 R4 was found sitting on floor next to low bed and sustained 2 areas of purple discolorations to left forearm with this fall.

Care plan dated 5/9/2011 notes R4 to be at risk for falls due to fractured hip, unaware of physical restrictions, unsteady gait, and attempting to walk without walker. This care plan identifies the use of bed alarm to remind R4 of safety issues. Physical Restraint/Enabler Assessment (not dated) notes 1/2 side rails 4/18/2011, low bed with side rails 7/10/2011, and self releasing seatbelt with alarm 7/11/2011. The Cognitive Assessment dated 8/5/2011 notes a score of 3 indicating R4 is severely impaired.

According to the Minimum Data Set dated 10/25/2011, Section P Restraint, siderails are not being used for R4 but a trunk restraint is used daily. Observation on 10/25, and 10/26/2011 at 9:00 am found R4 sitting in the dining room in a wheelchair. On both days it was observed that a chair alarm, body alarm and seatbelt (not self

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releasing) was being used for R4. Observation of R4's bedroom on 10/25/2011 and 10/26/2011 at 9:15 am observed that there were no 1/2 siderails present and a low bed was being used. During an interview on 10/26/2011 at 12:00 pm with E14 (Registered Nurse), when asked about the non releasing seatbelt being used for R4. E14 stated "she kept taking the self releasing one off."

2. R13 a 91 year old man residing in this facility since 8/26/11 according facility admission records. The Physician Order Sheets dated 9/1/2011 lists R13's diagnoses to include: Cellulitis, Anemia, Congestive Heart Failure, Bone Marrow Failure and Euthyroid Sick. A review on 11/02/2011 of R13's record finds admission nurses note dated 8/26/2011 documenting R13 has a history of climbing out of bed and wandering, alert and oriented to self, confused, resistive to care, uncooperative, aggressive to staff and other residents, attempts to get up without assistance, incontinent, mobile per wheelchair and can self propel.

Care plan dated 9/12/2011 notes R13 has risk factors that require monitoring and intervention to reduce potential for injury including unsteady/unsafe transfer or ambulation. Fall Risk Assessment dated 9/1/2011 score is 21 (high risk). The Side Rail Consent dated 8/26/2011 is incomplete. The Side Rail Assessment dated 9/3/2011 identified the need for 1/2 siderails for enabler, transfers, and positioning. The Minimal Data Set dated 9/9/2011 notes BIMS score of 3 out of 15, and the Care Area Assessment for falls indicate R13 is increased risk for falls due to generalized weakness, and decreased cognitive awareness, and R13 has 1/2 siderails and

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personal body alarm related to his falls.

A review on 11/02/2011 of nurses notes for accidents/incidents for R13 identify 5 falls from 9/1/2011 thru 10/7/2011. On 9/1/11 R13 was found on floor in his room, stated staff pushed him down, 9/22/11 found on floor by maintenance man, 10/1/11 found on floor in front of bedside commode, 10/4/2011 found on floor in front of bedside commode after being left unattended, and 10/7/11 found on floor by bedside commode. This review finds nurses notes on 9/27/2011 of R13 having a bed alarm, a reclining chair with feet elevated preventing R13 from getting up without assistance on 9/5, 9/13, 9/14 and 9/18/2011, a personal body alarm 8/26/2011, and chair alarm 9/15/2011. Further review of R13's record fails to find documentation of assessments for the use of the bed alarm, chair alarm, personal body alarm, or reclining chair, or whether these interventions were appropriate for R13. There is no documentation of post fall review for the falls of 9/22, 10/1, 10/4, or 10/7/2011. There are also nurses notes in the record 9/5, 9/11, 9/17, 9/21, and 10/7/2011 of R13 removing the alarms, and a nurses note dated 10/8/2011 stating R13 continues to get up without assistance.

During an interview at 2:00 pm with E14 (Registered Nurse) about the use of the reclining chair with the legs elevated to prevent R13 from getting up, E14 stated "sometimes that was the only way we could keep up with him and he usually went to sleep, no it was not being used as a restraint but to keep him from falling." No observations were made during this survey as R13 was discharged from this facility and

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F9999	Continued From page 63 admitted to the Illinois Veterans Home on 10/11/2011. (B)	F9999		