STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING _____ B. WING _____	C 04/19/2013

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LEROY MANOR	**509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752**

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F 323	Continued From page 43 dependent on staff for transfers and all activities of daily living. R10 transfers using a full mechanical lift. R10's Incident/Accident Reports document that R10 fell on 12/20/12, 02/27/13, and 03/15/13. The fall investigations dated 02/27/13 and 03/15/13 document that the root cause of R10's falls was that she was trying to get to the bathroom. The fall prevention intervention implemented after R10's fall on fall on 03/15/13 was "Encourage resident to ask for assistance prior to getting up." According to R10's MDS dated 02/05/13, R10 is severely cognitively impaired. Therefore, the fall prevention intervention "Encourage resident to ask for assistance prior to getting up" is inappropriate for R10 and fails to address the root cause of her falls.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240b) 300.3240d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The	F9999		

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policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.3240 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)

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify acts of witnessed verbal and mental abuse and failed to prevent the ongoing verbal and mental abuse of R2 by R3. These failures allowed the alleged perpetrator of the abuse, R3, who was R2's roommate, to have continued access to and continue to verbally and mentally abuse R2 for approximately four months. R2 was afraid to sleep at night for fear of what R3 might do to him when he was asleep. The abuse escalated resulting in a second perpetrator, R1 joining in on

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the mental abuse and attempting to hit R2 with his cane. R1, R2, and R3 are three of four residents reviewed for abuse on the sample of 25.

Findings include:

R1's Physician Order Sheets (POS) dated March 2013 document the following diagnoses: Memory Loss and Cognitive Communication Deficit. R1's Minimum Data Set (MDS) dated 01/29/13 documents that R1 is cognitively intact, independent with bed mobility, transfers, ambulation with a cane, and Activities of Daily Living (ADLs), and has impairment of range of motion of one of his lower extremities. R1's MDS documents no behavioral issues. R1's Care Plan updated 01/29/13 documents no behavioral issues. R1's Behavioral Observation Forms for 12/2012, 01/2013, and 02/2013, and 03/2013 were blank. The Achieve Report dated 04/15/13 documents that R1 was admitted to the facility on 08/03/12.

R2's POS dated March 2013 documents the following diagnoses: Infant Cerebral Palsy and Muscle Weakness with Difficulty Walking. R2's MDS dated 02/05/13 documents that R2 is cognitively intact, requires extensive assistance of two staff with bed mobility, transfers, and ADLs, and has bilateral impairment of range of motion of upper and lower extremities. R2's MDS documents no behavioral issues. R2's Care Plan updated 02/05/13 documents no behavioral issues. R2's Behavioral Observation Forms for 12/2012, 01/2013, 02/2013, and 03/2013 were blank. The Achieve Report dated 04/15/13

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documents that R2 was admitted to the facility on 03/24/06.

R3's POS dated March 2013 documents the following diagnoses: Difficulty Walking and Muscle Weakness. R3's MDS dated 02/12/13 documents that R3 is cognitively intact, independent with bed mobility, transfers, ambulation, and ADLs, and has no impairment of range of motion of his upper or lower extremities. R3's MDS documents no behavioral issues. R3's Care Plan updated 02/13/13 documents no behavioral issues. R3's Behavioral Observation Forms for 12/2012, 01/2013, and 03/2013 were blank. R3's Behavioral Observation Forms for 02/2013 records behaviors directed toward R2 and are described below. The Achieve Report dated 04/15/13 documents that R3 was admitted on 02/09/12.

On 03/14/13, the Resident Census Record documented that R2 and R3 began rooming together 11/20/12. On 03/14/13 at 4:00pm, R2 and R3 were still roommates.

On 03/14/13 at 3:30pm, R2 stated "I'm afraid of my roommate (R3). I'm afraid he'll come over and do something to me when I'm sleeping." R2 stated that he has difficulty sleeping at night due to his fear of R3 hurting him. R2 also stated that R3 turns the volume of his television and radio up loud during the night, which awakens him if he does get to sleep. R2 stated that R3 does not let him use the sink in the room, and will not allow him to keep his toiletries on the sink countertop/shelf. R2 stated that R3 calls him names and shoots spitwads at him. R2 stated that he had asked E1, Administrator, four times "if

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F9999	Continued From page 47 he (E1) could get me out of that room." On 04/15/13 at 10:40am, R2 stated that he felt abused by R3. R2 became upset when talking about how he was treated, (yelling)"They (staff) all saw it (the name calling, spit wads). They (staff) all knew!" On 03/14/13 at 11:42am R3 stated "I don't like him (R2). From the first time I saw him, I didn't like him. I call him 'dog-face' because he looks like a dog...I turn my TV and radio up loud and I don't care if it bothers him...I shoot spit wads at him" and demonstrated by blowing through a straw. R3 stated that he did not know R2 prior to becoming roommates. The Achieve Report dated 04/16/13 documents that R3 had a private room from 03/14/12 through 11/19/12. Social Service Documentation completed by E4, Social Service Director (SSD) dated "Late November (2012)" documents R2 reporting that "We (R2, R3) don't get along very well." R2 reports that R3 keeps his radio loud at night. Social Service Documentation completed by E4, SSD, dated "Mid December (2012)" documents that R2 reported they (R2, R3) are getting along "about the same," and that R2 is having trouble sleeping at night. On 04/15/13 at 9:02am, E4 stated that "about the same" meant that the issues with the lights on, television on, and noise from the radio during sleeping hours were unchanged from November 2012. E4 stated that she did not know that R2 and R3 were incompatible. E4 stated that the facility staff wanted to allow R2 and R3 a period of adjustment. E4 was unable to state what she	F9999		

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thought was a reasonable amount of time to allow for adjustment.

Social Service Documentation completed by E4, dated January 15, 2013, documents an email sent from E4 to E3, Assistant Administrator, asking staff to "help (R2) and (R3) problem solve. Also, if they could simply remind (R3) to turn down his radio, etc.," and "Can you ask your third shift staff ... to help keep the peace so that (R2) can get to sleep?" There is no other Social Service documentation until 03/14/13 when R2 was moved to a private room.

On 03/14/13 at 11:25am, R16 stated that R3 calls R2 "monkey man" and other rude names and taunts R2 in the dining room and in the lounge near the Nurse's Station. R16's MDS dated 03/19/13 documents that she is cognitively intact.

On 03/14/13 at 11:30am, R17 stated "One day I heard (R3) calling someone 'monkey man' and I asked 'Who is monkey man?' (R3) answered '(R2).' I told (R3) that wasn't nice, and R3 said 'Yes, I know that.'" R17's MDS dated 03/12/13 documents that she is cognitively intact.

On 03/14/13 at 12:25pm, E29, Certified Nursing Assistant (CNA) and First Shift Coordinator, stated that she had witnessed R3 throwing his placemat at R2 in the dining room, but cannot recall the date of the occurrence. E29 stated that she reported R3 throwing the placemat to a nurse, but she does not remember who the nurse was. E29 also stated that she had witnessed R3 call R2 "monkey man" and throw spit wads at R2 (E29 does not recall the date of the occurrence). E29 stated that she did not report the name

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calling or throwing spit wads. On 04/15/13 at 10:15am, E29 stated that all forms of abuse should be reported to the Administrator.

On 03/15/13 at 1:15am, E28, CNA, stated that one morning she found R2's toiletries on the floor. E28 stated that she started to put R2's toiletries on the sink countertop/shelf, and R2 told her not to because "(R3) won't like that-- (R3) put them there. (R3) will get mad." E28 stated that she did not report the incident because R2 did not want to make R3 mad. On 03/14/13 at 3:30pm, R2's toiletries were in a box on a chair in his room. On 04/15/13 at 2:45pm, E28 stated that all forms of abuse should be reported immediately to the Administrator.

On 03/15/13 at 1:17am, E26, CNA, stated that she had heard R3 call R2 names and make mean comments to R2 while working in their room. E26 stated that she did not report the name calling or mean comments.

On 03/14/13 at 3:00pm R1 stated that "He (R3) torments him (R2) and calls him names." R1 repeated and emphasized the word "torments." R1, who shared the same dining table as R3, stated that he sometimes joined R3 in calling R2 names during meals.

On 03/15/13 at 1:20pm E11, Registered Nurse (RN), stated that approximately one month ago he reported R3's behaviors to E2, Director of Nursing (DON). E11 stated that the behaviors he reported included name calling (ugly, stupid), spit wads, and putting R2's belongings on the floor of the room. E11 stated that he does not remember what E2 said in response to his reporting. R3's

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verbal and mental abuse of R2 continued. E11 did not check back with E2 before reporting the same concerns one week later to E1. E11 stated that E1 said he would take care of it.

On 04/15/13 at 12:37pm, E1 stated that he does not remember E11 reporting R3's behaviors to him.

On 04/15/13 at 11:40am, E9, LPN, stated that R2 had told her (date unknown) "(R3) is not being nice to me." E9 stated that she immediately reported the allegations to E2, DON, who replied "I'll take care of it."

On 03/14/13 at 3:30pm, E2, DON, stated that she "really doesn't remember specific issues, and that (she) asked (E4, SSD), to talk to (R2) and (R3) to see if anything needed to be done." E2 stated she did not report the allegations to E1. On 04/15/13 at 9:15am, E2 stated that she remembers only that R2 and R3 had roommate issues, so she referred the issue to Social Service. E2 stated that she doesn't remember who had reported the concerns to her, it was "too long ago."

On 04/05/13 at 2:40pm E4, SSD, stated that she was not aware of R3 calling R2 names, throwing the placemat, or shooting spit wads at R2, or R3 not allowing R2 to use the sink in his room or place his toiletries on the sink countertop. E4 stated that she did not ask R2 if he felt safe in his room. E4 stated she "probably should have asked more specific questions about what was happening."

R3's Behavioral Observation Form entries by E46, CNA, dated 02/13/13 at 4:00pm; 02/14/13 at

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4:00pm; and 02/21/13 at 4:00pm document R3 "insulting roommate, name calling when (R2) is in or out of earshot. (R3) clearly does not like (R2), and has no issues expressing his dislike in the form of verbal insults (nasty, mean remarks)." On 04/15/13 at 9:40am, E46 stated that when she witnessed the insults and name calling, she told another CNA (does not remember who it was). E46 stated that she was newly hired and wasn't sure what to do. E46 stated that R3's name calling and insults of R2 seemed to be "general knowledge" of the staff, so she thought that it had been reported. E46 stated that she was so busy she didn't report the name calling and insults, but now she knows that she should have reported them. E46 stated that name calling and insults are verbal and mental abuse.

On 04/15/13 at 11:25am, E47, Medical Records Staff, stated that she had worked as the Facility Weekend Manager on 03/09/13. E47 stated that when she arrived at the facility at 7:00am that morning, E17, CNA, reported to her that R3 had been calling R2 names in the dining room. E47 stated that E17 had reported R3's name calling to the nurse on duty (does not remember who the nurse was) at approximately 6:30am and the nurse had told R3 that name calling was inappropriate behavior, and if he would not stop the name calling, he would have to eat in his room. E47 stated that R3 went to his room and ate breakfast. E47 stated that after all of the residents had finished their breakfast meal, she notified the nurse of what E17 had reported to her regarding R3's name calling of R2.

On 03/14/13 at 3:30pm and 04/15/13 at 10:30am, R2 stated that he was seated in his wheelchair in

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the lounge, sitting still, when R1 came up to him and hit his wheelchair with his cane. R2 stated that R1 then threatened to hit him over the head with his cane.

On 03/13/13 at 3:00pm R1 stated that R2 had tried to run him down four times with his wheelchair. R1 stated that he went to E1 and told him R2 had tried to run him down with his (R2's) wheelchair and that the next time this happened, he (R1) was "going to bloody him (R2) up." R1 stated that at a later date he did raise his cane to hit R2, missed him (R2), and hit near the back of the wheelchair.

On 03/14/13 at 12:20pm E30, LPN, stated that she witnessed R1 hit the back wheel of R2's wheelchair with his cane, immediately separated R1 and R2, made sure they were safe, and then immediately reported the incident to E1, Administrator. E30 stated that R2 was seated in his wheelchair, sitting still, in the front lounge area when R1 walked past R2, and without provocation, hit R2's wheelchair with his cane. E30 stated she does not remember the date of this incident. On 04/15/13 at 10:27am E30 stated that when she reported this incident to E1, he said that he had talked to them (R1, R2) before and that he would take care of it.

On 03/14/13 at 4:00pm, E1, Administrator and Abuse Coordinator, stated that he does not have any records or investigations regarding the allegations of abuse involving R1, R2, or R3. E1 stated that he remembers R1 talking to him about issues with R2, but that he did not document or investigate the allegations. On 04/15/13 at

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F9999	Continued From page 53 12:37pm, E1 stated that he did not view R1 and R3's behaviors as abuse. E1 stated that he thought R1 and R3's behavior was more like "good old boys club" behavior (joking behavior). The Facility's Abuse Prevention Policy (revised 10/12) defines verbal abuse as "the use of oral, written, or gestured language that includes disparaging and derogatory terms to a resident...regardless of the resident's age, ability to comprehend, or disability." Mental abuse is defined as "humiliation, harassment, threats of punishment or deprivation, or offensive physical contact..." The Facility's Abuse Prevention Policy also directs that "The Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to the State Survey and Licensing Agency. The Administrator shall be responsible for resident's protection..." (A) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	F9999		

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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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 are not met as evidenced by:

Based on interview and record review, staff failed to have two staff persons assist with transfers as prescribed on R7's Resident Centered Care Information Sheet. During a one-person transfer, R7 was unable to pivot, her leg was twisted, and she sustained a fractured femur.

Staff failed to use a mechanical stand aid lift for transfers prescribed in R15's Care Plan. R15 fell forward while being manually transferred by one person while using her walker. R15 hit her head on the wall, sustaining a Head Injury and requiring two sutures to a Left Brow Laceration.

The facility also failed to ensure that root cause analyses were performed for falls sustained by R9, and failed to identify and implement appropriate fall prevention interventions for R10.

R7, R15, R9 and R10 are four of five residents reviewed for falls in the sample of 23.

Findings include:

1. R7's Physician Order Sheet (POS) dated

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	145674	A. BUILDING _____ B. WING _____	C 04/19/2013

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LEROY MANOR	**509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752**

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March 2013 documents the following diagnoses: History of Right Total Knee Replacement, History of Open Reduction and Internal Fixation of a Right Femoral Neck Fracture, Rheumatoid Arthritis, Muscle Weakness, and Senile Dementia.

R7's Minimum Data Set (MDS) dated 02/12/13 documents that R7 is severely cognitively impaired, requires the extensive physical assistance of two or more staff persons for transfers, bed mobility, and toileting.

R7's Resident Centered Care Information Sheet dated 01/28/13 documents that R7 is to have the assistance of two staff with transfers and toileting.

The Event Report dated 03/03/13 at 12:20pm documents that R7 experienced severe pain in her right leg after being transferred from her wheelchair to her bed. On 04/04/13 at 2:30pm, E32, Certified Nursing Assistant (CNA), stated that on 03/03/13 at 12:20pm she (E32) transferred R7 alone by herself, using a gait belt, with a stand-pivot transfer. E32 stated R7 was able to bear weight as usual. E32 stated that she heard "the usual cracks and pops" (of R7's body), and R7 moaned "a little" as she was transferred. E32 stated that when she placed R7's legs in the bed, R7 began to scream in pain. E32 stated that she did not drop R7, lower her to the floor, bump her leg, or catch her foot or ankle on the wheelchair. On 04/10/13 at 2:17pm E32 confirmed that she had transferred R7 alone by herself, using a gait belt and a stand-pivot transfer.

On 04/04/13 at 2:40pm E8, Licensed Practical

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Nurse (LPN), stated that she assessed R7's leg no more than three to four minutes after E32 reported R7's severe leg pain. E8 stated that R7's right thigh was 'hugely' swollen or deformed, and that E8 screamed with pain if she attempted to have R7 straighten her right leg.

On 03/03/13 at 12:39pm R7 went to the Emergency Room (ER) for evaluation. ER Radiology Reports dated 03/03/13 document "a spiral and somewhat comminuted fracture of the distal shaft of the femur with overlap of the fracture fragments."

On 04/04/13 at 10:23am, Z1, Physician, stated that "Everyone 90 years or older will have some degree of calcium loss from (their) bones, weakening them. (R7's) fracture is the result of putting (R7) back to bed from her wheelchair. There must have been some sort of twisting, They (staff) twisted her leg and broke it. (R7 had) obvious, immediate deformity and screaming pain, all at once. (R7) had no pre-existing, pathological condition that would cause this fracture."

On 04/10/13 at 2:01pm, E38, CNA, stated "(R7) is a two man transfer because she doesn't pivot-she can't pivot- when transferring. Physical Therapy told us we can downgrade her to a full mechanical lift (for transferring), also."

On 04/10/13 at 2:00pm, E27, MDS and Care Plan Coordinator, stated that R7 was to be transferred by two staff at all times. E27 stated that she had omitted addressing R7's transfer requirement on R7's Care Plan.

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On 04/10/13 at 2:03pm, E29, CNA First Shift Coordinator, stated that R7 was designated as a two person transfer on 01/28/13. R7's transfer needs were documented on the Resident Centered Care Information Sheet located on the unit in which R7 resided.

On 04/10/13 at 1:55pm, E40, Dementia Unit Coordinator, stated that R7 was a "two person transfer due to her poor weight bearing and difficulty pivoting."

On 04/10/13 at 1:55pm and 1:56pm respectively, E40, CNA, and E41, CNA, stated that R7 was to be transferred with the assistance of two staff persons.

On 04/14/13 at 2:00pm and 2:02pm respectively, E43, CNA, and E39, CNA, stated that R7 was to be transferred with the assistance of two staff persons.

2. R15's POS dated March 2013 document the following diagnoses: Muscle Weakness, Neuralgia, and History of Subdural Hematoma Following Injury.

R15's MDS dated 02/12/13 documents that R15 requires staff assistance to balance when moving on and off the toilet, when moving from a seated to standing position, and with surface to surface transfers.

R15's Care Plan dated 12/27/12 documents that R15 is to use a mechanical stand aid lift for all transfers.

On 04/05/13 at 12:10pm, E34, Certified

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Occupational Therapy Assistant (COTA), stated that the mechanical stand aid lift was the appropriate method of transfer for R15 from 12/27/12 through 04/03/13.

R15's Incident/Accident Report dated 03/08/13 at 4:33pm documents that R15 was standing at the toilet with her walker in front of her, waiting to use the toilet, while E35, Certified Nursing Assistant (CNA), was pulling down R15's pants. R15 fell forward on top of her walker, hit her head on the wall, and landed on the floor on top of her walker in the prone position. R15 had "blood to her left eye and left hand." R15 was transported to the hospital.

R15's Head Computerized Axial Tomography (CT) scan dated 03/08/13 documents "Extracranial soft tissue alteration/swelling/hematoma is demonstrated over the left periorbital region. No acute intracranial hemorrhage."

R15's Emergency Room Note dated 03/08/13 documents a one centimeter full-thickness laceration over the underside of the left eyebrow, actively bleeding. The laceration was closed with two sutures.

On 04/04/13 at 3:45pm, E35, CNA, stated that she did transfer R15 alone to the toilet room using her walker. E35 stated that she had been trained by E36, CNA, to transfer R15 with a stand-pivot transfer while using her walker. E36 no longer works at the Facility.

On 03/08/13, E35 received a written Employee Disciplinary Action for improperly transferring

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R15.

3. R9's POS dated March 2013 documents the following diagnoses: Senile Dementia, Difficulty Walking, Muscle Weakness, Fracture Transcervical Femur, Closed.

R9's MDS dated 01/15/13 documents that R9 requires extensive assistance from two or more staff for bed mobility and transfers, and is totally dependent on staff for dressing, bathing, and moving about the unit. R9 uses a wheelchair.

R9's Incident/Accident Reports document that R9 had six falls within two months: 01/13/13, 02/14/13, 02/18/13, 03/13/13, 03/24/13, 03/25/13.

R9's Fall Investigations dated 01/13/13, 02/14/13, 02/18/13, 03/13/13, 03/24/13 document that five of R9's falls were falls from his wheelchair. None of these five fall investigations documented an analysis of the fall which determined a root cause.

On 03/14/13 at 4:00pm, E1, Administrator, was unable to produce any root cause analyses for R9's falls.

On 04/05/13 at 4:00pm, E5, Regional Director, was unable to produce any root cause analyses for R9's falls.

4. R10's POS dated March 2013 documents the following diagnoses: Senile Dementia, History of Fractured Ankle, History of Face and Neck Injury with Laceration of Forehead.

R10's MDS dated 02/05/13 documents that R10

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F9999	Continued From page 61 is severely cognitively impaired and is totally dependent on staff for transfers and all activities of daily living. R10 transfers using a full mechanical lift. R10's Incident/Accident Reports document that R10 fell on 12/20/12, 02/27/13, and 03/15/13. The fall investigations dated 02/27/13 and 03/15/13 document that the root cause of R10's falls was that she was trying to get to the bathroom. The fall prevention intervention implemented after R10's fall on fall on 03/15/13 was "Encourage resident to ask for assistance prior to getting up." According to R10's MDS dated 02/05/13, R10 is severely cognitively impaired. Therefore, the fall prevention intervention "Encourage resident to ask for assistance prior to getting up" is inappropriate for R10 and fails to address the root cause of her falls. (B)	F9999		