STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145319	A. BUILDING _____ B. WING _____	02/25/2013

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HERITAGE HEALTH-EL PASO	555 EAST CLAY EL PASO, IL 61738

(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 520	Continued From page 70 49 residents.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS:| 300.610a) 300.1210b) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal Care 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.	F9999		

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F9999	Continued From page 71 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are NOT MET as evidenced by: Based on interview and record review the facility failed to separate and protect one resident from abuse (R21) in the supplemental sample. R21 was verbally and mentally abused during meals and when in room. The facility failed to separate R21 from the perpetrator (R16) for eight days during which time R21 and R16 shared the same room. Findings include: The facesheet for R16 documents an admit date of 4/16/2010 and includes the following diagnoses: Unspecified Disturbance of Conduct and Depressive Disorder Not Elsewhere Classified. MDS (Minimum Data Set) dated 11/15/12 for R16 documents a BIMS (Brief Interview for Mental Status) score of 10, indicating R16 was alert and oriented with periods of confusion. MDS dated 11/15/12 documents in section E0600 that R16 significantly disrupts care or the living environment. Nurse's Note dated 12/08/12 for R16 documents, "At 6:30 PM, I (E14/Certified Nursing Aide) went to put (R21) to bed. As I came into the room,	F9999		

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(R16) complained that the room's lights were on. I turned off the lights by the sink and (R16)'s overhead light and told (R16) that the other light would be turned off when I put (R21) to bed. The curtain was drawn-it was not shining on his face. (R16) said it was fine, I adjusted his blankets and he thanked me. As I got (R21) ready for bed, washing him, (R21) made sounds he always does. (R16) began yelling, telling (R21) to shut up. He (R16) said (R21) was an animal, that he was not paying to live in a barn or a zoo. He (R16) said take that animal out of his room, get rid of him. He (R16) cussed repeatedly and was verbally and mentally abusive. (R21)'s reaction was immediate. (R21)'s face turned bright red and he yelled back at first. Then (R21)'s began to cry. His face was hot and red and tears were flowing. He began to moan like he was in pain and turned his face towards the wall. It was then (R16) said, 'What's that noise? A cow? Am I living in a damn barn?' I was washing (R21) as quickly as I could and told (R16) that he was being unkind, that this was (R21)'s room also. He (R16) yelled that it was his room first and that (R21) was a monster, an animal and that it was unfair that he had to share a room with someone like him making stupid noises. (R21) quieted down but continued to cry. I tried to quietly reassure (R21) that we care for him and that (R16)was simply being unkind, but it made little difference, I went and reported to (E16/Registered Nurse) our nurse and stated that it was unfair to (R21) to be trapped in there, unable to leave the room, while being verbally and mentally abused by (R16), unable to respond to (R16)'s comments. (E16/Registered Nurse) called E2/Director of Nursing and E1/Administrator immediately. I (E14/Certified

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Nursing Aid) continued getting people ready for bed and then (E16/Registered Nurse) told me (E1/Administrator) said we would have to move (R16) to another room. I was alarmed and I told (E16/Registered Nurse) this would make the situation worse, that (R16) would really go into a rage. Around 7:30 I (E14/Certified Nursing Assistant) I spoke with (E2/Director of Nursing) and she told me to document this with Nurse's Notes. I (E14/Certified Nursing Assistant) told her everything that had happened, stated that (R21) had not provoked (R16), and that (R16) was being verbally and mentally abusive. I (E14/Certified Nursing Assistant) said that the situation would only escalate if (R16) was forced out of his room and she told me to tell (E16/Registered Nurse) to not move anyone yet, that she would talk to (E1/Administrator). I (E16/Certified Nursing Assistant) let (E16/Registered Nurse) know that we were not to move anyone and that I headed to find television ear phones for (R21). I told her that this would not solve the problem, that (R16) was making complaint's about (R21)'s disabilities-unable to speak and only make sounds. (R16) also makes rude comments during meals about (R21)'s noises. I (E14/Certified Nursing Assistant) but we were unable to hook them to the television."

Nurse's Note dated 12/08/12 for R16 documents, "CNA/Certified Nursing Assistant (E14) approached me (E16)and told me that (R21) was crying after being called a 'cow' and a 'monster' by his roommate (R16). (E14/CNA) had been doing (R21)'s HS (bedtime) cares when (R16) started making rude comments. (R16) complained of the lights being on and the noises his room mate makes. I (E16/Registered Nurse)

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went to check on both residents at this time. (R16) states to me that he can not get any rest because his room mate making noises. I (E16/Registered Nurse) check on (R21) and he is quiet in bed. His face is flushed and tear stains seen on his cheeks. I (E16/Registered Nurse) ask if he is OK, he makes no sound, does finally smile a little. I (E16/Registered Nurse) call (E1/Administrator) to ask if I may move (R21) due to (R16) being mean with comments as reported by CNA. She (E1/Administrator) tells me (R16) is the one who would have to move and go talk to him about it. She (E1/Administrator) said it could only be 'temporary'. E2/DON (Director of Nursing) calls for me. She (E2/DON) wants to know what E1/Administrator said, then she asks me what (R16) said and I told her I haven't been able to get back to him yet to see if he would move. E2/DON then asks to speak with E14/CNA. After that, (E14/CNA) told me not to do anything yet with the room change. She (E2/DON) is going to talk to (E1/Administrator). I go to (R16) and ask him if he would like to move to another room for the night. He (R16) becomes enraged, angry facial expressions-shakes his fist at me-yelling 'No, I am not moving! This is my room. I'm not leaving, move him. He is a b******. Leave me alone. (E2/DON) calls and asks for me and tells me to not only document all this to he but also in the resident charts and chart only the facts. I (E16/Registered Nurse) tell her what (R16) said about moving to another room. (E1/Administrator) calls and I tell her what (R16) said. She asks me if (R21) has the television on. I tell her yes, he likes it on. She (E1/Administrator) tells me to get (R21) some television headphones. I (E16/Registered Nurse) tell her that (R16) has not complained about the

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television but other stuff with (R21). (E1/Administrator) states, 'I am trying to come up with some solutions.' I (E16/Registered Nurse) ask what to do if I can not find head phones. She (E1/Administrator) said to borrow from someone. Tell her (E1/Administrator) I (E16/Registered Nurse) will call (E15/Maintenance Supervisor) if a problem, she (E1/Administrator) said not to. Ear phones have been found in maintenance room but unable to hook them up as a wire is missing. I (E16/Registered Nurse) call (E1/Administrator) to tell her. She (E1/Administrator) asks how they are doing and I tell her both are quiet. (R16) asleep (eyes shut) and (R21) is watching television and she (E1/Administrator) said okay."

Facility policy titled "Policy and Procedure Regarding Abuse and Neglect, Involuntary Seclusion, Misappropriation of Resident Property and Injuries of Unknown Origin" documents, "If another resident is the suspected perpetrator of the abuse, then the suspected resident shall be supervised 1:1 or kept physically separate from all other residents until further orders."

On 2/19/13 at 8:05 AM, E14/CNA verified the incident on 12/8/12 when R16 was verbally and mentally abusing R2. E14/CNA stated that R16 said R21 sounded like a cow, that it sounded like a zoo in there and R21 didn't deserve to share a room with him. E14/CNA stated R21 turned his head away and started crying. E14/CNA felt R21 understood what was being said about him.

On 2/19/13 at 8:35 AM, E16/Registered Nurse verified the incident on 12/8/12 when R16 was verbally and mentally abusing R21.
E16/Registered Nurse verified that R21 was left

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F9999	Continued From page 76 in the same room as R21 even though there were rooms open. E16/Registered Nurse stated she was told by E1/Administrator those rooms had to be left open for admissions. The facility weekly census report documents that R16 and R21 remained room mates from 12/8/12 (date of the incident) until 12/16/12. Behavior Tracking Progress Notes dated 12/12/13 for R16 documents, "(R16) announced at the supper table that he has to put up with (R21) all night. (R16 and R21 were table mates.) That (R21) is noisy all night long. (R21) looked sad, so we quickly praised (R21) for being a fine fellow that he is!" Behavior Tracking Progress Notes dated 12/13/13 for R16 documents, "(R16) yelling about us changing (R21) turning the light on." Behavior Tracking Progress Notes dated 12/17/13 (11-7 shift) for R16 documents, "Resident yelled at his room mate to shut up over there when room mate let out a sigh..." On 2/19/13 at 1:15 PM E1/Administrator verified that R16 was never supervised 1:1 or kept separate. On 2/19/13 at 1:15 PM E1/Administrator stated the reason R16 and R21 were not separated sooner is because R16 threw a fit and did not consider moving R21 from the room shared with R16. (A) LICENSURE FINDINGS: 300.610a)	F9999		

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F9999	Continued From page 77 300.1210b) 300.3240a)b)d)	F9999		

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 300.1210 General Requirements for Nursing and Personal Care
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall

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F9999	Continued From page 78 immediately report the matter to the facility administrator. 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. These Requirements are NOT MET as evidenced by: Based on interview and record review, the facility failed to be effectively administered in order to attain or maintain the safety of each resident in an effort to maintain each resident's highest practicable physical, mental, and psychosocial well being. The facility was not administered in a way to protect residents from abuse and neglect, or in a way to develop a system process to identify facility issues and implement corrective action. These failures have the potential to affect all 49 residents in the facility. The facility failed to identify residents who were at risk for being abused and residents who were at risk for abusing others. The facility failed to verify the eligibility of all CNAs (Certified Nursing Assistants) prior to the first day of employment. The facility failed to immediately report allegations of abuse/neglect to both the administrator and the Illinois Department of Public Health. The facility failed to thoroughly investigate allegations of abuse and to completely document those investigations and their conclusions. The facility failed to protect residents while investigating allegations of both resident to resident and staff to resident abuse. The facility failed to prevent misappropriation of resident medications. The	F9999		

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facility failed to have quarterly quality assessment and assurance committee meetings in order to identify and correct quality deficiencies. The facility failed to provide oversight and monitoring of staff performance related to infection control practices in the dietary department.

Findings include:

The CMS-672, Resident Census and Conditions of Residents, dated 2-13-13 and signed by E1/Administrator, notes the facility census to be 49 residents.

1. Facility Policy and Procedure Regarding Abuse, Neglect..," dated 8-21-12, states, in section 17, Screening, "Staffing levels will be determined by a review of resident need. A thorough analysis will encompass an in-depth assessment of the facility resident composition. Special attention will be given to identifying behavior that increases the resident's potential for abusing others, or self or being the victim of abuse.

On 2-14-13 at 1:45 PM, E1/Administrator stated that no formal assessment of residents is routinely conducted to identify behaviors that put residents at risk for abusing others or being the victim of abuse.

2. Facility failed to check the status of two CNAs (Certified Nursing Assistant) for several months after their dates of hire, potentially exposing residents to staff who had a previous finding of abuse/neglect.

3. In two of five abuse/neglect investigations,

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administration failed to immediately report the allegations to the state agency as required by facility policy.

4. In four of five abuse/neglect investigations, staff failed to immediately report the allegations to the administrator as required by facility policy. The administrator failed to recognize those staff failures and take measures to correct them.

5. In four of five abuse/neglect investigations, administration failed to protect the alleged victim of abuse while the investigation was ongoing.

6. In one of five incidents, the administration failed to identify reported incident as potential abuse, therefore failing to investigate. In addition, in five of five facility investigations of allegations of abuse/neglect , the investigation was incomplete and lacked accurate documentation. Upon review of the investigation documentation, administration could not provide key elements, including dates, times, or the names of alleged perpetrators. In addition, administration could not provide the outcome of the investigation or any corrective measures taken.

7. In two of five investigations, the administration failed to protect the resident victims from the potential from further abuse as follows: one resident who had been abused who was witnessed by staff to be verbally abused by roommate, was left with the roommate (perpetrator) for eight additional days; staff who had been accused of verbal abuse were not suspended pending investigation and were allowed to work an entire shift before it the allegation was determined to be unfounded.

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F9999	Continued From page 81 8. Two staff nurses (E4/LPN and E5/LPN) misappropriated a portion of the medication supply of one resident to use for another resident due to the failure of staff to obtain the medication by following the medication procurement policy and procedure. Both nurses, in addition to E2/ DON (Director of Nursing,) acknowledged knowing the policy and that it was inappropriate and against facility policy to do so. 9. There was no Quality Assessment and Assurance Committee meeting held for more than one year. E1/Administrator was responsible for ensuring the meetings were held, but failed to do so when they could not be arranged with the schedule of the Medical Director. 10. E17/Dietary Supervisor did not know the mechanism of action of the machine that was used for washing and sanitizing dishes. It was set up as a hot water sanitizer and regularly failed to achieve a high enough temperature to kill microorganisms, but E17 believed it was in chemical sanitizing mode and did not take action to correct the low temperatures until the failure was identified by survey staff. In addition, E17 was not aware that milk-based dietary supplements expired once they were thawed for 14 days, which was printed on the carton and failed to monitor that dietary staff was dating them once the were removed from the freezer. (B)	F9999		