	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		` ´COM	E SURVEY PLETED
		145818	B. WING				C <b>03/2013</b>
	PROVIDER OR SUPPLIER  ARE CENTER OF ROC	CKFORD		STREET ADDRESS, CITY, STATE, ZIP 707 WEST RIVERSIDE BOULEVAR ROCKFORD, IL 61103		10/	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 406	A Psychiatric Evaludischarge plan includischarge plan includischarge plan including properties of actions at the second process of t	ation for R8 dated 9/15/13 udes Individual Psychotherapy, py, Medication Monitoring, gram, and home. (no nursing  ector of Nursing) said when d about R8's recent suicide mented suicide watch every e monitoring sheets showed ere implemented on 9/19/13. vas a suicide risk on  at 2:45 PM, R8 wants to sign Medical Advise) I don't know agree he is a sick man. valking down the road in front plastic bag on 9/25/13 at 3:30	F 4				
	300.1220b)3)10) 300.3240a) 300.3240b) 300.3240c)						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		E SURVEY PLETED
		145818	B. WING				C <b>03/2013</b>
	PROVIDER OR SUPPLIER	CKFORD		7	TREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	10/	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa 300.3240d) 300.3240f)	ige 41	F99	99			
	Section 300.610 Re	esident Care Policies					
	procedures govern facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shall	advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed					
	c) The written polic the following provis	ies shall include, at a minimum ions:					
	including categories not accepted, resid discharged, transfe	sfer and discharge of residents, s of residents accepted and ents that will be transferred or ers within the facility from one and other types of transfers;					
	Section 300.1210 ( Nursing and Person	General Requirements for nal Care					
	a) Comprehensive	Resident Care Plan. A facility,					

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		145818	B. WING				C
	PROVIDER OR SUPPLIER		B. WING	S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE 07 WEST RIVERSIDE BOULEVARD COCKFORD, IL 61103	<u>  10/</u>	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	resident's guardiar applicable, must de comprehensive ca includes measurals meet the resident's and psychosocial resident's comprehallow the resident practicable level of provide for dischar restrictive setting be needs. The assess the active participar resident's guardiar	age 42 on of the resident and the or representative, as evelop and implement a re plan for each resident that ole objectives and timetables to a medical, nursing, and mental needs that are identified in the nensive assessment, which to attain or maintain the highest independent functioning, and age planning to the least passed on the resident's care sment shall be developed with attorn of the resident and the or representative, as in 3-202.2a of the Act)	F99	999			
	and services to att practicable physica well-being of the reeach resident's corplan. Adequate an care and personal resident to meet the care needs of the shall include, at a procedures:  c) Each direct care be knowledgeable respective resident to sub	section (a), general nursing at a minimum, the following					

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		145818	B. WING				0
NAME OF F	PROVIDER OR SUPPLIER	143010	D. WINO		TREET ADDRESS, CITY, STATE, ZIP CODE	10/0	03/2013
	ARE CENTER OF ROC	KFORD		7	07 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa seven-day-a-week l	-	F99	999			
	resident's condition emotional changes, determining care re further medical eva	rations of changes in a , including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the record.					
	assure that the resi as free of accident nursing personnel s	ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see ecceives adequate supervision prevent accidents.					
	Section 300.1220 S Services	Supervision of Nursing					
		upervise and oversee the the facility, including:					
	each resident base comprehensive ass and goals to be acc and personal care a representing other s activities, dietary, a are ordered by the the preparation of the plan shall be in writing	p-to-date resident care plan for d on the resident's ressment, individual needs complished, physician's orders, and nursing needs. Personnel, services such as nursing, and such other modalities as physician, shall be involved in the resident care plan. The ing and shall be reviewed and with the care needed as					

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	PROVIDER OR SUPPLIER  ARE CENTER OF ROC	CKFORD		7	TREET ADDRESS, CITY, STATE, ZIP CODE 07 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	10/	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999		age 44 sident's condition. The plan it least every three months.	F99	999			
	residents and their	the screening of prospective placement in terms of services ing competencies available.					
	Section 300.3240 A	Abuse and Neglect					
	agent of a facility sl	ee, administrator, employee or hall not abuse or neglect a ection 2-107 of the Act)					
	aware of abuse or immediately report	ee or agent who becomes neglect of a resident shall the matter to the facility tion 3-610 of the Act)					
	abuse or neglect of report the matter by	strator who becomes aware of f a resident shall immediately by telephone and in writing to esentative. (Section 3-610 of					
	who becomes awar resident shall also	strator, employee, or agent re of abuse or neglect of a report the matter to the on 3-610 of the Act)					
	investigation of a re resident indicates, that another reside	etrator of abuse. When an eport of suspected abuse of a based upon credible evidence, nt of the long-term care facility f the abuse, that resident's					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		145818	B. WING				C 03/2013
	PROVIDER OR SUPPLIER  ARE CENTER OF ROC	CKFORD		7	STREET ADDRESS, CITY, STATE, ZIP CODE 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	10/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	determine the most placement for the roof that resident as v	ige 45 immediately evaluated to it suitable therapy and esident, considering the safety well as the safety of other oyees of the facility. (Section	F99	999			
	These Requiremen by:	ts are not met as evidenced					
	Based on observation, record review, and interview, the facility failed to protect residents (R5, R4, R16) from verbal and physical abuse by a resident with a known history of physical and verbal aggression. The facility failed to have behavioral interventions in place to protect other residents. The facility neglected to follow their policies related to Admission, Violence Prevention, and the Management of Aggressive and Combative Behaviors. This failure resulted in 3 residents (R5, R4, R16) being physically abused by R1.						
		17 residents reviewed for , R16) in the sample of 17.					
	The findings include	e:					
	to the facility on 8/1 R1's September, 20 documents that R1 Unspecified Schizo	013 Physician's Order Sheet 's diagnoses include					

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		145818	B. WING		<del></del>		C <b>03/2013</b>
	PROVIDER OR SUPPLIER  ARE CENTER OF ROO	CKFORD		STREET ADDRESS, CITY, 707 WEST RIVERSIDE E ROCKFORD, IL 6110	BOULEVARD	10/	33/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULE CED TO THE APPROP EFICIENCY)	) BE	(X5) COMPLETION DATE
F9999	Illness and other remoderate cognitive assessment shows symptoms. R1 requires only sure Activities of Daily Laweighs 156 pounds R1's Abuse Risk In 8/23/13 documents possible abuse. R1 risk for possible ag A hospital Social V documents that R1 behavior and psychological points of the same report shows that R1 hith The same report shows that R1 was threatening (previous facility) R Psychiatric Hospital placements in which assaulted other results and 30 years of living institutions or group said that R1 can not go. He is a potential	R1 has a Serious Mental plated conditions. R1 has impairment. The same of that R1 has had no behavioral apervision in most of his priving. R1 is 6 feet tall and so the serious as a score of 2 (0-2 = low) for its scored as 1 (0-2 = low) for gressive behaviors.  Work Consult dated 6/20/13 has a history of aggressive cal and verbal. The report its room mate three times. However, and refusing his medication R1's diagnoses included or, Agitation, Irritability, phts, and Non-compliance with occumented that Z4 reported its to kill other residents. In has had approximately 15 lizations, and multiple facility h R1 threatened or physically	F99	99			

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		145818	B. WING				C <b>03/2013</b>
	PROVIDER OR SUPPLIER  ARE CENTER OF ROC	CKFORD		70	TREET ADDRESS, CITY, STATE, ZIP CODE 07 WEST RIVERSIDE BOULEVARD BOCKFORD, IL 61103	10/	33/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	residential facility.  R1's (nursing note: until 9/24/13, R1 re  R1's Nursing Notes and physical aggreday after his admis  On 8/17/13 R1 curresident in the show altercation with a diresident got to clos R1 said " Look Bitche Fk are you doifcking hands to you fcking hands to you fcking ass bitch." ("Don't you touch the nurse help him."  8/23/13 R1 continuous help him."  8/23/13 R1 struck a because he was sit 8/26/13 Verbal alter R1 very agitated aft up her clothes expos 8/27/13 R1 constar when "mad."  8/30/13 Cursed at schocolate milk.  9/4/13 R1 was yell understand what he 9/5/13 Yelling and of (two occurrences)	s) showed that from 8/16/2013 fused medication 13 days.  It document numerous verbal serve behaviors beginning one sion to the facility. (8/17/13)  It sed and screamed at a male wer room. R1 got into a second ifferent resident when that e to R1 and touched his leg. h, I will kick your Ass. What ing touching me. Keep your ourself. I'm going to kick your Other residents were yelling, at man, don't hit him, nurse,  The set to have behaviors of verbally aggressive to other another resident in the head. It ing in his chair. The resident (R17) pulled being her body to R1. Intly cursing, difficult to redirect estaff because there was nothing and cursing staff unable to	F99	199			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER  ARE CENTER OF ROO	CKFORD		7	TREET ADDRESS, CITY, STATE, ZIP CODE 07 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	lunch. 9/12/13 R1 very ho hospital. R1 says h transferred to the h day. 9/16/13 If anyone n would start yelling a 9/16/13 3:00 PM, R another resident ca out of his chair. R1 yelling and the other face. R1 then struct the head. R1 has b cursing at everyone  9/17/13 while on the resident. R1 struck head. (12:45 AM) 9/17/13 Nursing No (Administrator) resi second floor to his downstairs the nurs R1 was very agitate 9/18/13 R1 began y 9/18/13 7:00 AM, R this, Fck that." R1 resident swinging, y 9/20/13 5:45 AM CI room mate ready for bed and said to the here bitch?"  2:00 PM R1 walking swearing at staff ar 2:30 PM R1 sat at o the other resident a	d swearing. Tabusive to another resident at stile, wants to go to the ewill call 911. R1 was ospital, and returned the same nade eye contact with R1 he and cursing as if to start a fight. I had an altercation with lled her a Bitch and said to get sat down next to her and kept or resident slapped R1 in the kithat resident in the back of een walking around all day he sees.  The first floor R1 hit another the resident on the face and the shows "Per E1 dent (R1) is to return to the room. He spent the night for downstairs aid that he downstairs" welling "F.ck You" to the staff. I yelling and screaming "Fck started toward another very hard to redirect. NA entered R1's room to get or dialysis. R1 got up out of CNA "What are you doing in gothroughout the facility and other residents. Sining room table and called to the table a "Bitch", R1 was er resident. When staff told R1	F99	199			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		145818	B. WING		10	C / <b>03/2013</b>
	PROVIDER OR SUPPLIER	CKFORD		STREET ADDRESS, CITY, STATE, ZIP COD 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103		700/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F9999	that R1 has a beha and strikes out at o R1 will have no evid The approaches ind medications as ord to protect the rights Approach and spea attention, remove from 9/24/13 at 9:30 that R1 initiates agg (R1) thinks people and R16, he said she warguing with R4 (see (R1) to first floor an and R1 hit him. E6  On 9/24/13 at 2:00 said on the day that brought R1 to the firoom with R5. R1 of flips, he flips."  On 9/24/13 at 5:45 rapidly back and for the dinner meal. R1 going up to resident close) R1 pulled the another resident (R1 around, he did redirection.  2. R5's diagnoses Depression, Demender the procession of the side of the close of the	ed through 12/3/13 documents vior problem. Resident swears ther residents. The goal is that dence of behavior problems. clude: administer his ered. Intervene as necessary and safety of others. ak in a calm manner. Divert rom the situation.  AM, E6 (Psycho/Social) said gression toward others. He are talking about him. He hit as in his chair. R1 was econd floor) so they sent him ad put him in the room with R5 said that they just try.  PM, E3 (Registered Nurse) t R4 egged on R1, they rst floor and put him in the an be helpful, but "when he  PM, R1 was observed pacing rth in the dining room during I was talking to himself, and ts and standing by them.( very be phone out of the hand hand hand hand hand hand hand hand	F99	999		
		ntia, and Anxiety, according to in Order Sheet (POS). R5's				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COM	E SURVEY IPLETED
		145818	B. WING				C <b>03/2013</b>
	PROVIDER OR SUPPLIER  ARE CENTER OF ROC			707	REET ADDRESS, CITY, STATE, ZIP CODE WEST RIVERSIDE BOULEVARD CKFORD, IL 61103	1 10/	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Minimum Data Set resident is cognitive easy and has intern The MDS notes R5 transfers, ambulation bathing. He ambula careplan of 4/2/201 impaired individual and Paranoia.  On 9/17/2013, Nurs AM, R5 was in his to in his room, began repeatedly strike R8 Nursing notes state combative.  On 9/24/2013 at 11 to sleep. They mov my room. I wasn't it was strange they the night. He [R1] ocurtain screaming, on the head. I had hadn't even spoker why he would be vifor help, he was ha anything, I couldn't aide came in to help room because he wextremely violent. I [R1] pounded my he was violent beformy room]. I don't woom in the middle with more than one	of 6/21/2013 documents the ely intact. The resident startles mittent periods of lethargy. Trequires supervision with on, dressing, hygiene and ates using a walker. R5's 3 shows the resident has coping related to Depression sing Notes document at 12:45 ped. R1, who had been placed yelling at R5 and started to 5 on his face and head. R1 was very vulgar and resident in the middle of came over on my side of the hollering, and hammered me no idea why he was so mad. In to him. I don't know know olent against me. I hollered mmering on me. I couldn't do move, I just hollered and the proposition may be a headache. He ead with his fists. They knew they brought him down [to want those violent people in my of the night. He has trouble		999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	E SURVEY PLETED
		145818	B. WING				C <b>03/2013</b>
	PROVIDER OR SUPPLIER  ARE CENTER OF ROO	CKFORD		STF <b>707</b>	REET ADDRESS, CITY, STATE, ZIP CODE WEST RIVERSIDE BOULEVARD CKFORD, IL 61103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F9999	diagnoses includes history of substance and Aggressive Be showed R4 is at me and is at high risk for On 9/24/2013 at 9:: Director) said on 9/arguing and fighting during the argument 4. R16's Septembershow that R16's dia Disorder and Anxied documents R16 was R16's MDS Assess that R16 has mode has behavior that in at others. R16 requor more persons for ambulate and uses A Psychiatric Progredocuments that R1 same report shows toward staff.  R16's Behavior Cashows toward staff.  R16's Behavior Cashows that R16 has aggressive by scrain has poor impulse of others. The goal is two episodes of agthrough the next re R16's care plan for	Ing Form documents R4's Bipolar Disorder II. She has a ele abuse disorders. An Abuse havior Screening of 8/9/2013 edium risk for possible abuse or aggressive behavior.  30 AM, E6 (Psychosocial 17/2013, R4 and R1 were g. R1 slapped R4 in the head ont.  31 Physician's Orders agnoses include Depressive ty. R16's Face Sheet as admitted on 7/29/13.  32 Ament of 8/7/13 documents rate cognitive impairment. R16 includes verbal abuse directed aires extensive assistance of 2 or transfer. R16 does not a wheel chair for mobility.  33 Ament of 8/13/13  34 Ament of 8/13/13  35 Ament of 8/13/13  36 Ament of 8/13/13  37 Ament of 8/13/13  38 Ament of 8/13/13  39 Ament of 8/13/13  40 Ament of 8/13/13  41 Ament of 8/13/13  42 Ament of 8/13/13  43 Ament of 8/13/13  44 Ament of 8/13/13  45 Ament of 8/13/13  46 Ament of 8/13/13  47 Ament of 8/13/13  48 Ament of 8/13/13  49 Ament of 8/13/13  40 Ament of 8/13/13  41 Ament of 8/13/13  42 Ament of 8/13/13  43 Ament of 8/13/13  44 Ament of 8/13/13  45 Ament of 8/13/13  46 Ament of 8/13/13  47 Ament of 8/13/13  48 Ament of 8/13/13  49 Ament of 8/13/13  40 Ament of 8/13/13  41 Ament of 8/13/13  42 Ament of 8/13/13  43 Ament of 8/13/13  44 Ament of 8/13/13  45 Ament of 8/13/13  46 Ament of 8/13/13  47 Ament of 8/13/13  48 Ament of 8/13/13  49 Ament of 8/13/13  40 Ament of 8/13/13  40 Ament of 8/13/13  41 Ament of 8/13/13  41 Ament of 8/13/13  41 Ament of 8/13/13  42 Ament of 8/13/13  43 Ament of 8/13/13  44 Ament of 8/13/13  45 Ament of 8/13/13  46 Ament of 8/13/13  47 Ament of 8/13/13  48 Ament of 8/13/13  49 Ament of 8/13/13  40 Ament of 8/13/13  40 Ament of 8/13/13  40 Ament of 8/13/13  41 Ament of 8/13/13  41 Ament of 8/13/13  41 Ament of 8/13/13  41 Ament of 8/13/13  42 Ament of 8/13/13  43 Ament of 8/13/13  44 Ament of 8/13/13  45 Ament of 8/13/13  46 Ament of 8/13/13  47 Ament of 8/13/13  47 Ament of 8/13/13  48 Ament		999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		COMPLETED	
		145818	B. WING		10	C / <b>03/2013</b>	
NAME OF PROVIDER OR SUPPLIER  ASTA CARE CENTER OF ROCKFORD				STREET ADDRESS, CITY, STATE, ZII 707 WEST RIVERSIDE BOULEVA ROCKFORD, IL 61103	P CODE	700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F9999	verbally abusive be review. The approaches in agitated intervene. The Incident Repowas involved in a with R16. R1 kept contact" with R1 ar R16 reported that I According to the Alpolicy: Physical Abuse is opinching, kicking, a through corporal powerbal Abuse is deor gestured languadisparaging and defamilies, or within tregardless of their disability. The same policy slallegedly mistreat a from contact with the five signature of the investigation condition shall be indetermine the most approaches, and pher safety, as well residents and empower of the investigation condition interview surveyor confirmed following steps:	chavior through the next clude when R16 becomes before agitation escalates.  It dated 9/16/13 shows that R1 rerbal and physical altercation yelling at R16 and she "made and he "made contact back." R1 hit her in the head.  buse Prevention Program defined as hitting, slapping, and controlling behavior		99			

NAME OF PROVIDER OR SUPPLIER  ASTA CARE CENTER OF ROCKFORD    CAN JUD   PREFIX   EACH DEPROCEMENT   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   FROM DEPROCEMENT   PREFIX   PREFIX   PROVIDERS PLAN OF CORRECTION SIGNALD BE CHAST   PREFIX   PREFIX	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ASTA CARE CENTER OF ROCKFORD    X4,1D    SUMMARY STATEMENT OF DEFICIENCIES   PROCKFORD, IL 61103     X4,1D    SUMMARY STATEMENT OF DEFICIENCIES   PROCKFORD, IL 61103     X4,1D    SUMMARY STATEMENT OF DEFICIENCIES   PROCKFORD, IL 61103     X6,4D DEFICIENCY WIST SE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS     F9999   Continued From page 53   9:30 PM.   PROVIDER'S PLAN OF CORRECTION GOALD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     A li mentally ill residents will be reviewed for potential of physical aggressive/explosive behaviors and the care plans will be revised.     Completion date of 9/30/13.   Stay Calm.     b. Move the resident into a private room away from other residents.     c. Use a team approach by getting staff to help.     d. Have a one to one with the residents.     e. Call the psychiatrist and have the patient seen with in 24 hours.     f. Call the Administrator, Director of Nursing, Doctor and family.     g. Call the police if you feel your safety is in danger.     4. All staff will be inserviced prior to working the floor on proper policy and procedures in handling residents that display physical aggressive and/ or explosive behavior. Inservicing of staff will be completed by 9/30/13.     (A)   300.615e)			145010					
ASTA CARE CENTER OF ROCKFORD    TOT WEST RIVERSIDE BOULEVARD ROCKFORD, IL. 6 1130		200//055 05 01/55/155	145818	B. WING		TREET ARRESTON OFFICE THE CORE	10/	03/2013
FREEIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F9999  Continued From page 53 9:30 PM.  2. All mentally ill residents will be reviewed for potential of physical aggressive/explosive behaviors and the care plans will be revised. Completion date of 9/30/13.  3. Actions to be taken when dealing with a physical aggressive explosive behavior resident: Inservicing completion on 9/30/13.  a. Stay Calm. b. Move the resident into a private room away from other residents. c. Use a team approach by getting staff to help. d. Have a one to one with the residents. e. Call the psychiatrist and have the patient seen with in 24 hours. f. Call the Administrator, Director of Nursing, Doctor and family. g. Call the police if you feel your safety is in danger.  4. All staff will be inserviced prior to working the floor on proper policy and procedures in handling residents that display physical aggressive and/ or explosive behavior.Inservicing of staff will be completed by 9/30/13.  (A)  300.615e)					7	07 WEST RIVERSIDE BOULEVARD		
9:30 PM.  2. All mentally ill residents will be reviewed for potential of physical aggressive/explosive behaviors and the care plans will be revised. Completion date of 9/30/13.  3. Actions to be taken when dealing with a physical aggressive and/or explosive behavior resident: Inservicing completion on 9/30/13.  a. Stay Calm. b. Move the residents. c. Use a team approach by getting staff to help. d. Have a one to one with the residents. e. Call the psychiatrist and have the patient seen with in 24 hours. f. Call the Administrator, Director of Nursing, Doctor and family. g. Call the police if you feel your safety is in danger.  4. All staff will be inserviced prior to working the floor on proper policy and procedures in handling residents that display physical aggressive and/ or explosive behavior. Inservicing of staff will be completed by 9/30/13.  (A)  300.615e)	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLÉTION	
	F9999	9:30 PM.  2. All mentally ill respotential of physical behaviors and the completion date of 3. Actions to be tak physical aggressive resident: Inservicing a. Stay Calm.  b. Move the resident from other residents. Use a team appred. Have a one to one. Call the psychiati with in 24 hours.  f. Call the Administ Doctor and family. g. Call the police if y danger.  4. All staff will be informed from proper police in the police of y danger.  4. All staff will be informed from proper police in the police of y danger.  300.615e)	sidents will be reviewed for aggressive/explosive care plans will be revised. 9/30/13.  en when dealing with a cand/or explosive behavior grompletion on 9/30/13.  In tinto a private room away so coach by getting staff to help. The with the residents. First and have the patient seen carator, Director of Nursing, you feel your safety is in serviced prior to working the cay and procedures in handling any physical aggressive and/or Inservicing of staff will be 13.	F99	999	DELIGIENCI)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145818	B. WING				C 03/2013
NAME OF PROVIDER OR SUPPLIER  ASTA CARE CENTER OF ROCKFORD				70	TREET ADDRESS, CITY, STATE, ZIP CODE  OF WEST RIVERSIDE BOULEVARD  OCKFORD, IL 61103	10/0	J3/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	300.615 Determination Request for Reside Information e)In addition to the 2-201.5 (a) of the A shall, within 24 hour resident, request a check pursuant to the Information Act for seeking admission background checks pursuant to the Hos Background checks resident's name, day	ation of Need Screening and nt Criminal History Record screening required by Section ct and this Section, a facility as after admission of a criminal history background the Uniform Conviction all persons 18 years or older to the facility unless a was initiated by a hospital cipital Licensing Act. It is shall be based on the stee of birth, and other the stee of State in the	F99	99			
	on the Illinois Sex C www.isp.il.us and th Corrections sex reg	check for the individual's name offender Registration web it at the Illinois Department of istrant search page at the to determine if the individual ered sex offender.					
	This REQUIREMEN	NT is not met as evidenced by:					
	The findings include	e:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145818	B. WING				C 03/2013
NAME OF PROVIDER OR SUPPLIER  ASTA CARE CENTER OF ROCKFORD				7	TREET ADDRESS, CITY, STATE, ZIP CODE 07 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	10/	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT AG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)		D BE COMPLETION	
F9999	failed to check all of State Police, Identi of Corrections) to criminal history.  This has the potent residing in the facility Data SI residents reside in R1, 4, 6, 10 & R13 checks. R1 had n R4 was not checked Corrections web site State Police review Department of Cornot have a Illinois Si Congliatory said simedical leave. E5 trained to do them;  The facility's undata residents states: In required by Section Section, a facility si admission of a residents of a residents of conviction Information years or older seek unless a background the conviction pursuant to state of the state of	y and record review the facility of the required sites (Illinois fied Offender, and Department determine if a resident has a tial to effect all 106 residents ity.  es:  neet of 9/24/2013 shows 106 the facility.  were reviewed for background o background checks done; ed in the Department of te: R6 did not have an Illinois y; R10 was not checked in the rections web site; and R13 did State Police background check.  00 PM, E7 (Care Plan said E11 (Social Services) is on (Community Liaison) has been	F99	999			

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		145818	B. WING		10	C / <b>03/2013</b>	
NAME OF PROVIDER OR SUPPLIER  ASTA CARE CENTER OF ROCKFORD				STREET ADDRESS, CITY, STATE, ZIP COD 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103		700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F9999	identifiers as require Police. (Section 2-2) The facility shall choon the Illinois Sex Cat www.isp.il.us and Corrections sex reg	ate of birth, and other ed by the Department of State 201.5(b) of the Act)  eck for the individual's name offender Registration web site if the Illinois Department of gistrant search page at it to determine if the individual	F99	999			