STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(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 56 utilization of QAPI audit tools... In Eagle Room meeting discuss patients with mood and behavior symptoms..." On 9/11/13 at 11:45 a.m., E3 (DCD - Director of Care Delivery) verified resident to resident aggression and wandering behaviors have not been addressed during Quality Assurance meetings stating,"Not as a whole." E3 (DCD) stated Eagle Room meetings are held with staff twice daily. On 9/11/13 at 8:45 a.m., E1 (Administrator) stated,"...We (Quality Assurance Committee) meet monthly... We have not been discussing anything with the residents and behaviors with the residents only staff abuse..." The Resident Census and Conditions of Residents form complete by E1 (Administrator) dated 9/08/13 states there are 67 residents residing at the facility. On 9/11/13 at 11:30 a.m., E17 (CNA - Certified Nursing Assistant) verified R16 wanders throughout the entire building. On 9/11/13 at 9:25 a.m., R22 stated,"... (R16 and R18) go all over the building. Just ask anybody..."	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

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F9999	Continued From page 57 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. Restorative measures shall include, at a minimum, the following procedures: 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	F9999		

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	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

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F9999	Continued From page 58	F9999		

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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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 were not met as evidence by:

Based on observation, interview, and record review the facility failed to protect all residents from potentially being abused, failed to recognize multiple incidents of abuse, and failed to report suspected physcial/verbal abuse to the Administrator and the State Agency for two of 13 residents (R5,R16) reviewed for abuse in the sample of 15 and one resident (R18) on the supplemental sample. R16 and R18 continue to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 59 ambulate throughout the facility into the rooms of other residents and become verbally and physically aggressive with other residents. R5 propels in a wheelchair throughout the dining room and hallways and becomes physically aggressive with other residents. The failure to report and investigate has allowed the above residents (R5, R16, R18) to continue wandering throughout the facility putting other residents at risk.This failure has the potential to affect all 67 residents residing in the facility. Findings include: On 9/09/13 at 2:00 p.m., a group meeting was held with R2, R15, R21, R22, R23, and R24. R18 was present in the meeting area but unable to participate due to cognitive deficits. R18 randomly called out loud answers to questions asked of the group members but the answers R18 called out were rambling, incomplete, phrases unrelated to the questions asked of the group. R2 indicated discretely the group could not speak freely with R18 present. At that time, R18 got up from the table and wandered to the door of the room. R18 opened the door but did not exit the room and returned to the table and sat down. E15 (Activity Aide) was summoned to distract R18 and escort R18 from the area to provide privacy for R2, R15, R21, R22, R23, and R24 to speak freely. After R18 left the meeting area the residents present for the group meeting reported there are two residents who repeatedly wander in and out of their rooms, R16 and R18. R2, R15, R21,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

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F9999	Continued From page 60	F9999		

R22, R23, and R24 all agreed R18 wanders into their rooms and becomes argumentative when they ask (R18) to leave. R2 reported R18 has wandered into (R2's) room and picked up (R2's) belongings and left the room with R2's belongings. R2, R15, and R22 reported R16 enters their rooms and becomes argumentative, refuses to leave, and they are afraid R16 will become physically abusive towards them before they can summon staff to intervene.

R2, R15, and R22 reported R16 enters their rooms and becomes argumentative, refuses to leave, and they are afraid R16 will become physically abusive towards them before they can summon staff to intervene. R2, R15, R21, R22, R23, and R24 reported wandering residents have been an on going problem. R2, R15, R21, R22, R23, and R24 indicated staff are aware of the behaviors of R5, R16, and R18 because residents called staff to intervene at the time of the incidents.

1. On 9/11/13 at 9:25 a.m., R22 stated, " ... I was sound asleep and (R16) came in with (R16's) walker and rammed my bed with (R16's) walker. I was sound asleep and it scared the heck out of me. The stop sign was up but that don't stop (R16). (R16) just comes on in anyway. It happened just the first of this week. (R16) informed me (R16) would leave when (R16) got ready. (R16) did finally leave. I didn't call staff. (R16) is always into something all the time. A year or so ago (R16) rammed into me with (R16's) walker intentionally, but I didn't get hurt. It's happened at least four to five times or more that (R16's) comes in here like that ... " R22 stated R16 and R18 go all over the building wandering into rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 61	F9999		

On 9-11-13 at 8:30 a.m., R36 stated the following: "(R16) always enters my room and I don't like it." R16 will enter R36's room and yell at R36. About a month ago, R16 approached R36, while in the hallway, and started shoving R36 with a walker.

On 9-10-13 at 3:45 p.m., E12 (Certified Nursing Aide) stated the following: R16 ambulates to all the hallways and into all of the resident rooms within the facility. R16 uses the walker as a weapon and attacks other residents with it. R16 attacks R22 with the walker frequently using R16's body and walker to shove R22, nearly causing R22 to fall. R16 will antagonize the other residents until the other residents get mad, and then R16 will say, "Well my work is done here. You are mad." E12 stated, "I have not reported (R16) attacking other residents to anyone, because I am just use to (R16) being like this all of the time."

On 9-10-13 at 3:45 p.m., E12 stated R16 attacked R36 with a walker while in the hallway on 6-16-13. E12 stated R16 shoved R36 with a walker at least three times before E5 (Registered Nurse) intervened. E12 stated the stop signs that are on the resident doors do not mean a thing to R16, as R16 just removes them and enters the residents' rooms anyway.
E12 stated, "I did not report this incident between R16 and R36, because I thought the nurse was aware."

On 9-10-13 at 4:45 p.m., E5 (Registered Nurse) stated R16 is a wanderer and other residents will yell for staff to come and remove R16 from their rooms. E5 stated R22 does not like R16 and will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 62 get very "verbal" with R16. R16's most recent quarterly MDS (Minimum Data Set) dated 7/13/13 documents under section E Behavior, Wandering occurred daily but did not intrude on the privacy of others. R16's most recent full annual MDS dated 10/10/12 documented R16 did not have behaviors but wandered daily and the wandering significantly intruded on the privacy or activities of others. R16's progress notes dated 10/25/12 through 9/5/13 document multiple occurrences of wandering and aggression. On 11/4/2012 R16's Progress Notes documented "increased wandering this shift, redirection unsuccessful, becomes increasingly agitated with staff." On 11/4/12 a Mood Behavior Progress note documented R16 showed symptoms of anxiety and demonstrated behaviors "such as wandering." The note documented R16 "interferes with other residents care at times." On 12/7/12 R16's Mood/Behavior Progress notes documented "increased agitation and verbal abuse with staff." On 1/11/13 R16's Mood Behavior note documented "up wandering in halls. Went into another resident's room, when asked to leave told other resident R16 did not have to, then left and went into another residents room and had to be escorted out by staff." On 1/25/13 R16's General Progress note documented "up wandering in halls. went into another residents room, when asked to leave the room R16 was easily upset and verbally abused staff. Then left room and went into another	F9999		

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	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 63	F9999		

residents room and had to be escorted out by staff."

On 5/29/13 R16's Mood/Behavior note documented "increased agitation and yelling at other residents."

On 6/16/13 R16's General Progress note documented "R16 very agitated and hitting other residents and refusing to leave and leave them alone. R16 also hitting staff members with walker."

On 7/12/13 R16's Social Service Progress note documented "more confusion and short tempered, can become agitated and try to be aggressive with others. Redirection does not always work."

On 8/7/13 R16's Mood/Behavior Progress note documented "wandered into room 103, resident in 103 asked R16 nicely to leave", staff attempted to redirect R16 to R16's room. The note documented R16 "became agitated and began scratching, hitting, cussing and spitting on staff."

On 9/10/13 at 11:00 a.m. R16 was barefooted walking around a parked wheelchair in the front hallway by the main entrance of the facility. R16 appeared confused but responded verbally to staff with abrupt answers to their questions. R16 was argumentative but did eventually sit in the wheelchair at staff's repeated request. R16 was able to transfer self.

On 9/11/13 at 11:30 a.m. E17 CNA (Certified Nursing Assistant) stated R16 wanders throughout the entire building in the afternoon and evenings. E17 stated R16 ambulates into other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

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F9999	Continued From page 64 resident rooms and may yell at them. On 9/10/13 at 11:50 a.m. E5 RN (Registered Nurse) stated R16 usually shoves R16's walker at the staff at hits at mostly staff and some residents. E5 stated R16 irritates other residents and wanders into their rooms. On 9/10/13 at 10:45 AM. E2 DON (Director of Nursing) stated R16 ambulates independently throughout the facility with a walker and enters other residents rooms. E2 stated the stop signs on the doors of other residents' rooms are to prevent R16 from entering those rooms. E2 stated R16 is not verbally appropriate and gets very agitated. R16 stated neither physical nor verbal abuse has been reported to E2 regarding R16. E2 denied being informed of the alleged resident to resident abuse that occurred between R16 and R36 on 6/16/13. On 9/10/13 at 12:40 p.m. R20 and R30 stated the red stop sign is on their door to prevent R16 from entering. R20 and R30 stated R16 is "not a very nice person." On 9/10/13 at 12:55 PM. R25 stated the stop sign is on R25's door due to R16 coming into R25's room and taking things. 2. On 9-8-13 at 9:30 a.m., R5 was propelling self, in a wheelchair, down the hallway. R5's Physician Order Sheet (POS) documents R5 has diagnoses of senile dementia and depression. R5's Mood/Behavior notes dated 2-7-13 at 1:48	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

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F9999	Continued From page 65	F9999		

p.m., document R5 grabbed a visitor by the wrist and hand, squeezing, and attempted to hit the visitor. The notes document E9 (Registered Nurse) attempted to reorient and calm R5, which was unsuccessful.

R5's Mood/Behavior notes dated 2-21-13 at 2:18 p.m., document R5 refused morning and noon medications, threatened to throw milk on staff, pinched, and kicked.

R5's Mood/Behavior notes dated 3-7-13 at 6:16 p.m., document R5 was found in another resident's room. When E7 (Activity Director) tried to remove R5 from the room, R5 grabbed and hit E7. The notes document R5 was "angry" and "wanted to hurt everyone" and R5 continued to hit, pinch, bite, and pull E7's hair.

R5's General Progress notes, signed by E5 (Registered Nurse) and dated 8-14-13 at 10:13 p.m., document R5 started hitting and grabbing other residents and the residents were separated.

On 9-9-13 at 11:15 a.m., E5 stated on 8-14-13 R5 grabbed, scratched, and kicked R16. E5 stated R5 is always grabbing and scratching other residents and the staff just try to re-direct E5. E5 stated E5 did not report the incident on 8-14-13, between R5 and R16, to E1 (Administrator) or anyone. E5 stated, "I only notify (E1) or the Director of Nursing if there is injuries."

On 9-9-13 at 12:00 p.m., E5 stated the incident on 8-14-13 might have been between R5 and R2. E5 stated R5 grabbed and pinched R2 on the arm, and the staff had to separate R5 and R2.

On 9-9-13 at 11:25 a.m., E6 (Certified Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 66	F9999		

Aide/CNA), stated R5 is always pinching, kicking, and biting the staff and residents. E6 stated R5 always bickers with R5's roommate. E6 reports R5 can propel self, in the wheelchair, down the hallway and in the dining room.

On 9-10-13 at 3:45 p.m., E12 (CNA) stated, "a few weeks ago, (R5) grabbed (R2)'s right wrist and would not let go." E12 stated it took E12 and E5 to get R5 to let go of R2's wrist.
E12 stated E12 did not report this incident to anyone because E5 was aware.

On 9-9-13 at 1:30 p.m., R2 stated that about two weeks ago R2 got too close to R5 in the dining room and R5 grabbed R2's right arm and would not let go. R2 states, "I think (R5) has a streak of meanness."

On 9-9-13 at 11:20 a.m., E1 (Administrator) stated all resident to resident altercations should be reported immediately to E1, E2 (Director of Nursing), the resident's family, and the resident's Physician.

On 9-9-13 at 12:45 p.m., E1 verified E1 has not been notified of any resident to resident altercations involving R5 and therefore, an investigation has not been done and the state agency has not been notified.

On 9-9-13 at 1:00 p.m., E1 (Administrator) stated, "all resident to resident altercations are considered abuse, regardless of the residents having dementia."

The Facility ' s Patient Protection Practice guide dated 11/2011 documented "when investigating whether abuse has occurred, the center identifies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 67 and considers events such as behavioral changes, bruising of patients, and suspicious patient patterns, unexplained injuries, communication or social interaction changes and other trends may signify abuse. Any allegation requires investigation. Any allegation of abuse must be immediately reported to the supervisor and abuse prevention coordinator. The center must ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administrator and other officials in accordance with state law through established procedures (including to the state survey and certification agency)." The Resident Census and conditions of residents dated 9-8-13 and signed by E2 (Director of Nursing/DON), documents 67 residents currently reside in the facility. (A)	F9999		