Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001812	A. BUILDING: ______ B. WING ______	C 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW CR CTR-LEWISTOWN	**175 EAST SYCAMORE LEWISTOWN, IL 61542**

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS
300.510e)
300.610a)
300.1210b)
300.1210d)6)
300.3240a)
300.3240d)
300.3240f)
Section 300.510 Administrator
e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities.

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 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 300.1210 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

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/02/14

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S9999	Continued From page 1 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other	S9999		

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S9999	Continued From page 2 residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on observation, record review and interview, the facility failed to adequately assess a resident prior to placement in the facility, failed to identify a resident as potentially dangerous to the safety of others, failed to ensure resident protection from physical and sexual abuse, and failed to recognize aggressive, physical behaviors directed towards others as abuse, for one of five residents (R1) reviewed for abuse, in a sample of seven. The facility failed to contact local law enforcement after an assault which resulted in serious bodily injury for one of five residents. These failures resulted in R1 striking R3 and R5 in the head/face and R1 making sexual advances towards R5 and R6. Additionally, R1 struck R2 in the face resulting in R2 sustaining multiple facial bone fractures and a subdural hematoma. R1 has been allowed to remain in the facility without an established monitoring system in place. The facility failed to follow operational policies and procedures regarding the pre-admission screening of residents, regarding residents who are Identified Offenders and for the identification, reporting, and investigation of abuse for one of five residents. The facility failed to ensure a known Identified Offender who displayed aggressive behaviors was supervised while in the	S9999		

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presence of other residents and failed to establish an effective monitoring program for one of two residents (R1) determined to be Identified Offenders, in a sample of five. The facility failed to effectively manage operations in order to provide for, attain, and maintain the safety of each resident and to maintain each resident's highest practical physical, mental, and psychosocial well-being (R1) reviewed for abuse, in a sample of seven. Failure has the potential to affect all 70 residents living in the facility.

Findings:

The facility policy, titled "Abuse Prevention Program (no date)", documents "This facility desires to prevent abuse, neglect, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Concern Identification and Follow-up: Resident and family concerns will be recorded, reviewed, addressed and responded to using the facility's concern identification procedures......Resident Assessment: As a part of the resident social history evaluation and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment or misappropriation of resident property, or who have needs and behaviors that might lead to conflict." Additionally, the "Abuse Prevention Policy" documents, "Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy,

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care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility."

Hospital Emergency Room documentation, dated 7/29/14, documents R1 as a "muscular 44 year old male" and having the diagnoses of Paranoid Schizophrenia and Dementia secondary to head trauma and heavy drug use. Hospital Emergency Room records indicate R1 was transferred to the Hospital from a Group Home, where R1 resided, for assaulting a female staff member with a can of soda and they did not feel it was safe for R1 to return.

A Hospital Consultation, dated 7/29/14, documents R1 as having an escalation in behaviors over the previous three months, including being aggressive towards residents and staff members at the Group Home and "getting into fights with other residents."

A Hospital Psychiatric Update, dated 7/31/14, documents information was obtained regarding R1's prior medical and criminal history. The Hospital Psychiatric Update identifies R1 as being housed in a forensic psychiatric unit for approximately two years, until 2006, for being deemed unfit to stand trial for a charge of Aggravated Battery after taking a golf club to someone's jaw.

On 9/10/14 at 10:18 a.m., Z2 (Hospital Social Worker) stated E1 (Administrator) came to the Hospital (on 8/04/14) to screen R1 prior to R1's transfer to the facility. Z2 stated E1 was given documentation regarding R1's medical history and "history of violent behaviors." Z2 stated (the facility) had knowledge of R1's criminal history, as it was documented in the Emergency Room

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S9999	Continued From page 5 Progress Notes, Psychiatric Consult, and History and Physical. The Electronic Medical Record, documents on 8/04/14, R1 was admitted to the facility with the diagnoses of Dementia with Behavioral Disturbances, Cocaine Dependence, Persistent Mental Disorder, Anxiety, Head Injury, Under socialized Conduct Disorder (Aggressive/Moderate), Paranoid Schizophrenia, and Depression. A Plan of Care for R1 was developed on 8/06/14; however, that Plan of Care failed to identify R1 as having a criminal history or the potential to demonstrate physical/verbal behaviors towards others. A Criminal History Response for R1 documents the facility requested R1's criminal history on 8/07/14 and the results were returned on 8/11/14. R1's Criminal History submitted by the State Police (dated 8/11/14) identified R1 as a Identified Offender and having multiple criminal charges, including Battery/Bodily Harm as recent at 4/03/14, Unlawful Possession of a Weapon by a Felon, Possession of a Firearm in Public, and Retail Theft. On 9/09/14 at 4:10 p.m., E1 (Administrator) stated the facility received R1's Criminal History Analysis on 9/02/14 and R1 was immediately placed in a private room and R1's care plan was updated to reflect the Identified Offender status. However, a Census List for R1 and R4 documents the residents were roommates from 8/26/14 to 9/07/14, until R5 was transferred to the hospital. On 9/10/14 at 1:35 p.m., R6 stated R1 came in to (R6's) room "about two weeks ago" and "tried to kiss (R6)." R6 stated (R6) immediately told E11	S9999		

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(Social Services) about the incident. R6 stated, "(R1) scares me."

On 9/10/14 at 1:40 p.m., E10 (Social Services) recalled R6 "telling (E10) something about (R1) going into (R6's) room", but could not recall details. E10 then provided documentation of a Social Service Progress note, dated 8/19/14, which documents R6 "came to care plan office and informed (E10) that (R1) came in to (R6's) room and (R6) does not want (R1) in her room....told resident (E10) will have a talk with (R1) about not coming into (R6's) room."

On 9/10/14 at 1:20 p.m., R5 stated (on 8/23/14) R1 had been "loitering" at the nurses ' station, and R5 followed R1 to see what R1 was doing. R5 stated R1 slapped (R5) across the face when (R5) got near R1. R5 stated, on another date (which R5 was unable to remember), (R5) was sleeping in a chair in the lobby area and R5 "grabbed my breast." R5 stated (R5) told the "nurse (unable to identify specifically who)" about the incident. R5 stated, "I'm afraid of (R1). Since (R1) came in, all sorts of problems started." R5 stated, "I felt safe, until (R1) came."

On 9/10/14 at 2:16 p.m., E7 (Memory Aide) stated (E7) was walking down the 300 Hall on 8/23/14 and saw R5 following R1 around the corner. E7 stated (E7) "heard a slap" and went in their direction to see what had happened. E7 stated R5 had a visible "red mark" on (R5's) face and R5 and R1 were separated. E7 immediately reported the incident to E3 (Licensed Practical Nurse), who called E1 (Administrator) to report the situation. E7 stated E1 (Administrator) never obtained a witness statement from (E7) regarding the incident.

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S9999	Continued From page 7 On 9/10/14 at 2:00 p.m., E3 (Licensed Practical Nurse) stated E7 did report the incident on 8/23/14 between R1 and R5 immediately to (E3). E3 immediately went into R1's room (which was shared with R3) to question R1 about the incident. E3 stated R1 admitted to hitting R5, but gave no reason why. E3 left R1's room and approximately five minutes later, another staff member (could not recall who) reported R1 had hit R3 in the left ear with R1's fist. E3 immediately moved R1 to a private room, and then called E1 (Administrator) to report both incidents. On 9/8/14 at 2:00 p.m., R3 stated on the evening of 8/23/14, R3 was in a wheelchair in the hallway by the West Nurses Station. R3 stated R1 walked up to R3 and hit him in the side of the head with a closed fist. R3 stated (R3's) head was "sore for a week or so." R3 stated "I did not say one word to cause him to hit me." R3 stated "(R1) must be a bit of a hot head" and "I'm very leery of (R1)." On 9/9/14 at 1:40 p.m., R1 was asked if R1 struck R3. R1 stated "yes, I hit him in the jaw. I just went up to him and punched him", while R3 "was in a wheelchair sitting in the hallway by the Roman clock (West Nurses Station)." R1 stated "I have a hard time keeping myself under control. I have a hard time keeping my temper." A Incident and Accident Reporting Form, dated 8/23/14, documents "(R1) being aggravated verbally by peer, turned and placed open hand on peers (left) cheek before (Memory Aide) could intervene. (R1) went immediately to room and roommate states (R1) placed closed hand into roommates (left) ear. Roommate states unprovoked. 1:1 assigned to this resident and resident relocated to empty room. Educated resident on keeping hands from others." The	S9999		

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S9999	Continued From page 8 Investigation Follow Up, dated 8/25/14, identified R1's room change and the 1:1 observation, which was initiated immediately following the incident, and a urinalysis as "new interventions" to prevent further altercations. The Investigation Follow Up failed to indicate how long the staff was to conduct 1:1 observation of R1 or if any increased monitoring was initiated after the 1:1 was discontinued. The Investigation Follow up failed to document either allegation of abuse as being reported to the State Agency and on 9/09/14 at 10:20 a.m., E1 (Administrator) confirmed that the incidents were not properly reported. R1's Plan of Care documents that the facility did not identify R1 as having the potential to demonstrate abusive behaviors until after the two incidents on 8/23/14. The interventions developed on 8/23/14 to decrease R1's abusive behaviors were: assess and anticipate resident's needs, assess resident's understanding of the situation, give the resident as many choices as possible about care/activities, monitor every shift, document observed behavior and attempted interventions in the behavior log, when the resident becomes agitated: intervene before agitation escalates, and change resident room away from peer (R3). R1's Electronic Medical Record documents R1 was placed in the room next to R3 on 8/26/14, three days after the 8/23/14 incident occurred. Observations of R1 and R3's room locations, made on 9/08/14 and 9/09/14, confirm that they remained in rooms directly next to each other. On 9/09/14 at 3:01 p.m., E12 (Housekeeping Staff) stated (E12) was in the dining room on 8/30/14, helping pass the supper trays. E12	S9999		

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observed R1 a "couple feet away" from R2, who was sitting in a (high back reclining wheelchair). E12 stated R1 stood up and hit R2 with "what looked like a closed fist." E12 stated E13 (Registered Nurse) helped intervene and took R2 to the nurses ' station to assess the injuries.

On 9/09/14 at 12:40 p.m., R9 stated (R9) was sitting in the dining room during dinner on 8/30/14 and R9 observed R1 look at R2 as R2 started wheeling into the dining room. When R2 got near R9's seat (which was close to R1's seat), R1 "just jumped up and punched (R2) in the face."

On 9/09/14 at 11:20 a.m., R10 stated (R10) observed R2 sitting in the wheelchair in the dining room on 8/30/14 at dinner. R10 stated R1 "just stood up and slugged (R2) in the face one time. (R2) couldn't defend himself."

On 9/09/14 at 11:04 a.m., R11 stated (R11) did not see R1 hit R2 on 8/30/14, but was present in the dining room. R11 heard a commotion, turned around and saw R2's "face bleeding and sunken in."

On 9/09/14 at 1:40 p.m., R1 stated "I just punched (R2) in the jaw." R1 offered no explanation as to why the incident occurred, other that stating "I have a hard time keeping myself under control."

An Incident and Accident Reporting form, dated 8/30/14, documents "(R2) had an altercation with other resident. Noting laceration to left side of face and bloody nose." The Incident and Accident Reporting form documents R2 was transported via ambulance to the Emergency Room on 8/30/14 at 5:30 p.m. The Investigation Follow Up, dated 8/30/14, documents R2 was

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"observed bumping wheelchair into other resident (R1). (R1's) right hand made contact with (R2's) left side of face ......Recommendations/Interventions: Immediately separated both residents, initiated every 15 minute visual checks with (R1), remove wheels from (R2's) chair so resident can't propel into other residents."

A Emergency Room Note Report, dated 8/30/14, documents R2 presented to the hospital as "patient apparently punched by another resident of the nursing home on the left orbit and cheek....Patient has advanced Dementia and is non-verbal.....CT (Computerized Tomography) Interpretation:.....large 2 cm (centimeter) thick left chronic subdural with this line of acute blood....complex left zygoma (cheek bone) fracture, comminuted with fracture of lateral orbital (bony wall of the eye) wall, orbital floor, maxillary sinus wall, with possible entrapment of inferior rectus (eye muscle)."

A written statement, provided by Z3 (Emergency Room Physician) on 9/11/14, documents "I cared for (R2) on the evening of 8/30/14 when (R2) presented to the Emergency Department. I received a brief verbal report from the nurses that the patient had been punched by another NH (Nursing Home) resident.....At the time I did review records from ED (Emergency Department) visits in May and July (2014). Patient had CT of head, neck and face in May for head injury including right maxillary sinus fracture, left frontal sinus fracture and nasal fracture. However, there was no subdural then on the Head CT. In July there were falls with no sign of head trauma. On the 8/30/14 visit the patient presented with severe bruising and swelling to the face with an obviously caved in cheek bone; the cheek

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fracture was easily seen and felt. There was a small cheek laceration. There was large swelling and bruising around the orbit and the eyeball was bruised. On the CT scan of the head, there was a large 2 cm thick chronic subdural. This blood surrounding the brain on the left side was not present on the May CT scan. There was no sign of head trauma on the July 16 visit. So sometime between May and 8/30 there was a significant head trauma that resulted in a severe injury to the brain causing a 2 cm thick layer of blood to form around the brain. It takes approximately a week for the blood to turn dark and show up as a chronic subdural. On the 8/30 CT there was a layer of fresh blood around the brain as well which was putting pressure on the brain to shift it several millimeters. In addition, the CT scan of the face showed the cheek bone had multiple fractures and was depressed, sunken in. There were also fractures to the left orbit and left maxillary sinus. The orbit fracture was so severe that the muscle that controls eye movement was trapped in the fracture. This happens only in a small percent of orbit fractures and denotes its severity. If (R2) had a much better baseline condition and a much better quality of life, (R2's) injuries would have been severe enough to transfer (R2) to the Trauma Center where (R2) may possibly have needed evacuation of the blood on (the) brain and reconstructive surgery on multiple facial fractures. This was not done because of (R2's) end staged dementia and very poor quality of life."
R1's Plan of Care was updated on 8/30/14 with a single added intervention to which was to initiate visual checks every 15 minutes to the previously identified "focus" of "potential to demonstrate verbally/physical abusive behaviors." The facility failed to identify any new "focus" areas on the Plan of Care or develop any other interventions.

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PRAIRIE VIEW CR CTR-LEWISTOWN	175 EAST SYCAMORE LEWISTOWN, IL 61542

(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) COMPLETE DATE
S9999	Continued From page 12 Behavior Notes, dated 9/05/14 at 4:24 p.m., document "(R1) noted with verbally threatening behaviors towards other male deaf mute resident (R4)." At 4:33 p.m., Behavior Notes document, "Female resident ambulating down 400 Hall independently, when this nurse witnessed (R1) turn towards female resident, stomping (R1's) foot and growling at her......(every) 15 minute checks initiated at this time." On 9/08/14 at 9:30 a.m., R1 was standing at the nurses ' station, mumbling incomprehensible comments as residents and staff walked by. R1 appeared in good physical health and is fully ambulatory. At 9:45 a.m., R1 wandered with R12 into R12's room, where they remained unsupervised approximately 3 minutes. R1 was observed at various times between 10:55 a.m. and 11:35 a.m. and was free to wander the facility independently. (A)	S9999		

Imposed

PLAN OF CORRECTION
Prairie View Care Center
175 East Sycamore
Lewiston, IL 61542

Cycle Date: August 27, 2014
Survey Date: September17, 2014
Survey Type: Complaint

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. We respectfully submit that this deficiency does not exist. To remain in compliance with all Federal and State regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F157
S/S= D

The facility will continue to notify the physician and family when there is an accident involving injury to a resident.

Corrective action for residents affected:
R4 was sent for a psychological evaluation and did not return.

How other residents will continue to be identified:
All residents have the potential to be affected by this alleged deficiency.

System revision:

1. The facility will continue to notify the physician and responsible party if a resident has an accident resulting in injury.
2. Nursing staff have been re-educated facility policy and procedure on notifying the physician and family when a resident has an injury.
3. E1, the Administrator at the time of the survey, no longer works at the facility. An interim Administrator has been placed in the facility.

How the facility will monitor system:

1. The Administrator or designee will audit 100% of incident reports over 4 weeks to ensure that all proper notifications were been made following an incident.
2. Identified trends will be discussed in the QA meeting and a plan for improvement will be discussed and implemented until resolution.

Completion date: 10/10/14

Acceptable

F223
S/S= L

The facility will continue to ensure that residents have the right to be free from verbal, sexual, physical, and mental abuse.

Corrective action for residents affected:

1. R1 was discharged from the facility on 9/9/14.
2. R3 and R5 were assessed for injury and treated per physician orders.
3. R5 and R6 were assessed for injury. No injuries noted. Residents were visited by Social Services in follow-up to discuss concerns.
4. R2 was treated at the hospital and returned to the facility.

How other residents will continue to be identified:
All residents have the potential to be affected by this alleged deficiency.

System revision:

1. Residents will continue to be provided necessary supervision to prevent physical abuse.
2. All staff received in-service training on the facility's abuse prevention policy and procedure as well as the requirements for reporting allegations of abuse to the acting Administrator.
3. The facility reviewed all resident care plans to ensure the resident is appropriate for the facility and to ensure the appropriate level of supervision is part of the resident's care plan.
4. E1, the Administrator at the time of the survey, no longer works at the facility. An interim Administrator has been placed in the facility.
5. The facility has reviewed its pre-admission screening procedure to ensure compliance.
   a. All new admissions will be properly assessed according to the abuse policy for a history of aggressive/harmful behaviors.
   b. All new admissions will have an Illinois state police background completed and the risk assessed according to the abuse policy.
   c. All new residents with a criminal hit will be placed on 15 minute checks until a risk assessment is received and evaluated by the facility.

How the facility will monitor system:

1. The interim Administrator or designee will audit 100% of incident reports for the next 4 weeks to ensure staff made timely and proper notifications of the allegation to the Administrator. Any identified failures to report allegations or suspicions of abuse will result in individualized retraining, and possibly discipline.
2. The interim Administrator or designee will conduct random interviews with residents each week for four weeks to ensure there are no allegations of abuse, neglect, maltreatment or misappropriation that were not reported to the Administrator. Any identified failures to report allegations or suspicions of abuse will result in individualized retraining, and possibly discipline.
3. The Acting DON will conduct investigations into any incidents/suspicious injuries that are not witnessed by staff.
4. The results of these audits will be presented to the QA Committee for follow-up as needed.

Completion date: 10/10/14

F225
S/S= L

The facility will continue to investigate allegations of abuse and report these allegations of abuse to the State agency.

Corrective action for residents affected:

1. R1 was discharged from the facility on 9/9/14.
2. R3 and R5 were assessed for injury and treated per physician orders.
3. R5 and R6 were assessed for injury. No injuries noted. Residents were visited by Social Services in follow-up to discuss concerns.
4. R2 was treated at the hospital and returned to the facility.

How other residents will continue to be identified:
All residents have the potential to be affected by this alleged deficiency.

System revision:

1. Residents will continue to be assessed per facility policy for potential to be abused and potential to abuse. Care plans will be updated as needed.
2. All cases of abuse allegations will immediately be reported to the Acting Administrator or Corporate designee.
3. Licensed Nursing staff were in-serviced on the facility abuse prevention policy and procedure on 9/9/14 and again on 09/25/14. The facility will provide ongoing training as needed.
4. All other staff were in-serviced on the facility's abuse prevention policy on 09/25/14 and again on 09/30/14. The facility will provide ongoing retraining as needed.
5. E1, the Administrator at the time of the survey, no longer works at the facility. An interim Administrator has been placed in the facility.
6. The Facility reviewed its policies and procedures for initiating and completing investigations to ensure compliance with all requirements.
7. The Facility reviewed its policies and procedures for making reports to appropriate agencies to ensure compliance with all requirements
8. Staff responsible for conducting investigations and making reports to agencies to be in-serviced on facility policy and procedure for initiating investigations, completing investigations and making appropriate reports to agencies.

How the facility will monitor system:

1. The interim administrator, corporate consulting, or designee will investigate all allegations of abuse and will make all necessary reports to the State and local law enforcement as needed.
2. The acting director of nursing or designee will investigate all unwitnessed accidents and incidents or suspicious injuries of unknown origin. Results of the investigation will be shared with the Administrator to ensure proper reporting requirements are met.
3. The administrator will audit all incident reports for 4 weeks to ensure proper investigations and reports to state agencies. The results of the audit will be documented and provided to the Quality Assurance Committee to verify compliance and for follow-up as needed.

Completion date: 10/10/14

F226
S/S= L

The facility will continue to follow the abuse prevention policy and procedure to maintain the safety of all residents.

Corrective action for residents affected:

1. R1 was discharged from the facility on 9/9/14.
2. R3 and R5 were assessed for injury and treated per physician orders.
3. R5 and R6 were assessed for injury. No injuries noted. Residents were visited by Social Services in follow-up to discuss concerns.
4. R2 was treated at the hospital and returned to the facility.

How other residents will continue to be identified:
All residents have the potential to be affected by this alleged deficiency.

System revision:

1. All allegations of abuse will be thoroughly investigated.
2. The facility has reviewed its pre-admission screening procedure to ensure compliance.
   a. All new admissions will be properly assessed according to the abuse policy for a history of aggressive/harmful behaviors.
   b. All new admissions will have an Illinois state police background completed and the risk assessed according to the abuse policy.
   c. All new residents with a criminal hit will be placed on 15 minute checks until a risk assessment is received and evaluated by the facility.
3. Licensed Nursing staff were in-serviced on the facility abuse prevention policy and procedure on 9/9/14 and again on 09/25/14. The facility will provide ongoing training as needed.
4. Social Service Director and Business office manager were in-serviced on the facility pre-screen policy included in the abuse prevention policy by Corporate Compliance RN 9/9/14.
5. E1, the Administrator at the time of the survey, no longer works at the facility. An interim Administrator has been placed in the facility.
6. The Administrator will investigate and report all allegations of abuse.

How the facility will monitor system:

1. The interim administrator or designee will audit all potential admissions for 4 weeks to ensure all facility policies and procedures are being followed regarding resident screenings.
2. The interim administrator or designee will audit all new admissions for 4 weeks to ensure appropriate supervision is initiated for all residents who have been identified as having a history of aggressive behaviors.

   The results of these audits will be presented to the QA Committee for follow-up as needed.

Completion date: 10/10 /14

F323
S/S= L

The facility will continue to provide the services that ensure that residents are provided appropriate supervision and interventions to prevent accidents.

Corrective action for residents affected:

1. R1 was discharged from the facility on 9/9/14.
2. R3 and R5 were assessed for injury and treated per physician orders.
3. R5 and R6 were assessed for injury. No injuries noted. Residents were visited by Social Services in follow-up to discuss concerns.
4. R2 was treated at the hospital and returned to the facility.

How other residents will continue to be identified:
All residents have the potential to be affected by this alleged deficiency.

System revision:

1. Residents will continue to be provided necessary supervision to prevent physical abuse.
2. The facility reviewed all resident care plans to ensure the resident is appropriate for the facility and to ensure the appropriate level of supervision is part of the resident's care plan.
3. Staff were in-serviced on facility policy and procedure on how to identify residents needing supervision for behaviors and how to provide appropriate supervision to residents with behaviors.
4. Staff have been instructed to document any aggressive resident behaviors in the resident's medical record and to report all incidents related to those behaviors to the acting DON or designee for follow-up.
   The acting director of nursing will conduct investigations into reports of aggressive behaviors, accidents and/or incidents per facility policy and procedure.
5. E1, the Administrator at the time of the survey, no longer works at the facility. An interim Administrator has been placed in the facility.
6. E2, the DON at the time of the survey, no longer works at the facility. An acting DON is in place.

How the facility will monitor system:

1. The interim administrator or designee will audit all new admissions for 4 weeks to ensure appropriate supervision is initiated for all residents who have been identified as having an history of aggressive behaviors.
2. The DON will audit all resident care plans to identify all residents who have a care plan requiring additional supervision and will conduct random observations for 4 weeks to ensure that facility staff are providing the level of supervision provided in the care plan.
3. The results of these audits will be presented to the QA Committee for follow-up as needed.

Completion date: 10/10/14

Acceptable

F490
S/S= L

The facility will continue be administered in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Corrective action for residents affected:

1. R1 has been discharge from the facility 9/9/14.
2. R2 was treated at the hospital and returned to the facility.
3. E1, the Administrator at the time of the survey, no longer works at the facility. An interim Administrator has been placed in the facility.

How other residents will continue to be identified:
All residents have the potential to be affected by this alleged deficiency.

System revision:

1. The facility has reviewed its pre-admission screening procedure to ensure compliance.
    a. All new admissions will be properly assessed according to the abuse policy for a history of aggressive/harmful behaviors.
    b. All new admissions will have an Illinois state police background completed and the risk assessed according to the abuse policy.
    c. All new residents with a criminal hit will be placed on 15 minute checks until a risk assessment is received and evaluated by the facility.
2. Residents will continue to be pre-screened according to abuse prevention policy and procedure.
3. Administrative and management staff have received in-service training of the facility's abuse prevention policy and procedure.
4. Residents will continue to be provided necessary supervision to prevent physical abuse.
5. The Facility reviewed its policies and procedures for initiating and completing investigations to ensure compliance with all requirements.
6. Staff responsible for conducting investigations and making reports to agencies to be in-serviced on facility policy and procedure for initiating investigations, completing investigations and making appropriate reports to agencies.
7. The facility will continue to notify the physician and responsible party if a resident has an accident resulting in injury.
8. The Facility reviewed its policies and procedures for making reports to appropriate agencies to ensure compliance with all requirements.

How the facility will monitor system:

1. The interim administrator, corporate consulting, or designee will investigate all allegations of abuse and will make all necessary reports to the State and local law enforcement as needed.
2. The director of nursing or designee will investigate all unwitnessed accidents and incidents or suspicious injuries of unknown origin. Results of the investigation will be shared with the Administrator to ensure proper reporting requirements are met.
3. The administrator will audit all incident reports for 4 weeks to ensure proper investigations and reports to state agencies. The results of the audit will be documented and provided to the Quality Assurance Committee to verify compliance and for follow-up as needed.

4. The interim administrator or designee will audit all potential admissions for 4 weeks to ensure all facility policies and procedures are being followed regarding resident screenings.
5. The interim administrator or designee will audit all new admissions for 4 weeks to ensure appropriate supervision is initiated for all residents who have been identified as having a history of aggressive behaviors.
6. The results of these audits will be presented to the QA Committee for follow-up as needed.

Completion date: 10/10/14

acceptable