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	IL6006852	A. BUILDING: _____ B. WING _____	09/09/2014

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ASTA CARE CENTER OF COLFAX	402 SOUTH HARRISON COLFAX, IL 61728

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS; 300.510e) 300.610a) 300.1210b) 300.1210d)3) 300.1220b)2) 300.3240a) 300.3240b) 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	S9999		

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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.
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.

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.
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. cf) Resident as perpetrator of abuse. When a investigation of a report of

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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 residents and employees of the facility.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to prevent repetitious sexual aggression and protect one resident (R16) from ongoing sexual abuse by another resident (R15), failed to implement facility policy and separate and protect one resident (R16) from multiple inappropriate sexual advances by another resident (R15), failed to report and investigate multiple allegations of sexual abuse between two residents (R15 and R16), and failed to operationalize their policy on abuse prevention and neglect. Furthermore, administration failed to recognize incidents of abuse, protect residents from potential further abuse and investigate multiple repetitious incidents as potential sexual abuse. R15 and R16 are two of five residents reviewed for abuse in the sample of 10. This has the potential to affect residents identified by the facility as vulnerable (R9, R13, R17, R21, R23, R24, R26, R27, R38, R45, R46), putting these residents at risk for sexual abuse.

Findings include:

The Facility Policy titled "Abuse Prevention Program" dated 2011, di[illegible]cts all employees to

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"report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about, or suspect to the administrator or an immediate supervisor who must then report it to the administrator....Supervisors shall immediately inform the administrator or in the absence of the administrator, the charge person in charge of the facility, of all reports, incidents, allegations or suspicion of potential abuse, neglect or misappropriation of property. Upon learning of the report, the administrator, or in the absence of the administrator the person in charge of the facility , shall initiate an incident investigation.....Residents who allegedly mistreat 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, care approaches and placement, considering his or her safety, as well as the safety of other residents and employees of the facility."

R16's Physician Order Sheet dated August 2014 documents the following diagnoses: Alzheimer's Disease and Cerebral Aneurysm. The Minimum Data Set for R16 dated 7/23/14 documents R16 with severe cognitive impairment and uses a wheelchair for mobility purposes. R16's Care Plan dated 7/23/14 documents that R16 is to be kept in high traffic areas for monitoring due to cognitive deficits and high fall risk.

R15's Physician Order Sheet dated August 2014 documents the following diagnoses: Depression, Alcohol Dependence and Insomnia. R15's Minimum Data Set dated 8/6/14 documents R15 with cognitive impairment, independent in ambulation and wanders. A facili[illegible] Psychiatric

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Evaluation dated 8/18/14 documents that R15 has good attention, concentration, insight is intact and R15's thought process is intact.

R15's Nursing Notes dated for 8/19/14 at 10:45 pm document "(R15) made advances towards another resident, found kissing, separated them, notified DON (Director of Nursing, E2)." The 8/19/14 entry was signed by E34, Licensed Practical Nurse. There are no further entries in R15's Nursing Notes related to behaviors.

Social Service Notes dated 8/19/14 document that R15 was found kissing another resident on the lips and E2 was notified. Social Service Notes dated 8/20/14 document that R15 was spoken to about kissing females on the lips and that it was inappropriate. The same note goes on to document "several staff members have seen him do it and it cannot happen anymore." The Social Service Notes are signed by E35, Social Service Director and have no time documented.

R16's Nursing Notes dated 8/19/14 at 10:45 pm document "(R16) found kissing another resident, separated the two and notified (E2)." The 8/19/14 entry is signed by E34. There are no further entries in R16's Nursing Notes related to behaviors.

R16's Social Service Notes dated 8/19/14 document "(R16) found kissing another resident on the lips. Both residents were separated (E2) notified. The 8/19/14 entry is signed by E35.

There was no further documentation in the Nursing Notes or Social Service Notes documenting that an assessment or interview had been done with R15 or R16.

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On 8/26/14 the facility provided a list of 12 residents that they have identified through assessment on 8/26/14 as being vulnerable to R15's inappropriate sexual behaviors. The list documents the following residents at risk for sexual abuse: R9, R13, R16, R17, R21, R23, R24, R26, R27, R38, R45 and R46.

The facility document titled "Wander Observation Record" for R15 begins with fifteen minute checks on 8/20/14 at 12:00 am and continues through 8/26/14 at 11:00 am. This same document has timed intervals of every fifteen minutes for staff to document R15's location in the facility. There is no documentation on the following times and or dates: 8/22/14 from 7:00 am through 3:15 pm and 8/24/14 from 4:45 pm through 9:45 pm. When E2 was shown the incomplete report on 8/26/14 at 10:45, E2 stated "I guess they weren't watching (R15)."

On 8/26/14 at 9:50 am, E2 stated she did not investigate the 8/19/14 incident when notified via telephone by E34. E2 stated it was her understanding that R15 was in R16's bathroom when the incident occured. E2 stated that nothing else had been reported to her.

On 8/26/14 at 10:00 am, E1 Administrator, stated she knew nothing about any allegations of sexual abuse. E1 acknowledged that she was aware of an incident on 8/19/14 of R15 and R16 being found kissing, but nothing else. E1 stated she assumed E2 had investigated the incident. E1 acknowledged she had not received any written investigation, documented interviews or assessments on either resident for this incident.

On 8/26/14 at 10:45 am E2, stated that she was aware of R15 and R16 kissing. E2 stated,

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"nothing else has been reported to me." E2 stated she had reported the incident to the Administrator, E1.

On 8/26/14 at 2:00 pm R15 was in his room and stated "I have never kissed anyone here or they would put me in jail in handcuffs and carry me away...." R15 stated "I like to kiss the girls' hands."

On 8/26/14 at 2:30 pm R16 stated she thought there was a man running around here touching people. R16 was not interviewable for additional information.

On 8/27/14 at 9:35 am E4, Dietary Manager stated "well I guess I better tell you this...last night as I was taking out the garbage (E30, Certified Nursing Assistant (CNA) came to me and told me that (R15) had been in (R16's) room playing with his penis in front of (R16) and (E15, CNA) had seen it but had not separated them. (E30) went in and took (R15) out of (R16's) room." E4 went on to say she had asked E30 if she reported the incident and E30 told her no, she thought E15 had reported it. E4 acknowledged at this time that she did not go to E1 with this allegation last night or this morning. E4 stated "I don't know why I didn't, I should have."

On 8/27/14 at 9:45 am E39, Dietary Cook stated she had entered the day room (was not able to remember the date) and saw R15 rubbing R16's arm. E39 stated there were two CNAs, E15 and E30 there at the time and both had stated they had caught R15 rubbing R16's private parts. E39 stated that this was a problem and needed to be reported. E39 stated that one of the CNAs (E15 or E30) said that the incident had been reported. E39 stated she did not report what she had

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heard.

On 8/27/14 at 9:58 am, E25, CNA stated she had heard something had happened between R15 and R16 over the weekend, but didn't ask anything further and she had not reported what she heard. E25 stated "I figured it wasn't my issue."

On 8/27/14 at 10:00 am, E15 stated that sometime last week (date unknown), E15 went into the day room and saw R15 with his pants unbuckled and his hands in his pants masturbating and R15 was bent over R16. E15 stated she separated R15 and R16 and reported the incident to E34, Licensed Practical Nurse. E15 stated that on Sunday 8/24/14, E15 went into the day room and heard R15 tell R16 "I want to suck your p****." E15 stated R15 was licking R16's face. E15 stated she reported this incident to E34, who stated to E15 "we just need to keep them apart, fifteen minute checks are already in place." E15 stated she thought E34 had reported this to administration.

On 8/27/14 at 11:10 am E34 stated she knew nothing of any incidents other than the incident of R15 and R16 kissing and she had reported that to E2. E34 then acknowledged that she had forgotten to document in R15's chart on 8/19/14 that R15 had been "touching himself" in front of R16 and had not reported to E1 or E2 that R15 was "masturbating" in front of R16.

On 8/27/14 at 1:00 pm E16, CNA stated that sometime last week, (could not remember the day) R16 was in R15's bathroom and R15 was kissing R16. E16 stated that R15 was also masturbating in front of R16. E16 stated she reported this to the nurse on duty and identified

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the nurse as E34.

On 8/27/14 at 3:25 pm, E30 stated that on Friday 8/22/14 she was working with E15. E30 stated that E15 had found R15 and R16 in the day room together and R15 was fondling R16's private parts through her clothes, but had not separated R15 and R16. E30 stated "I walked into the day room and (R15) was just about to start fondling (R16) again, but when (R15) saw me, I shook my head at (R15) and (R15) quit." E30 stated that she then removed R16 from the room. E30 stated "I did not report this, I thought E15 did."

On 8/27/14 at 3:35 pm, E22, CNA stated that sometime last week, (could not remember the day) E22 saw the door of R15's bathroom door open a crack and E22 could see the light on and she observed R16 in the bathroom also. E22 stated "(R16) is very confused and (R16) use to work here and sometimes goes around and empties others garbage cans." E22 went on to state that she saw R15 kissing R16. E22 stated she went in and immediately removed R16 from R15's bathroom. E22 stated she reported this incident to E34.

On 8/27/14 at 3:50 pm, E1 stated "I don't know why staff did not follow our policy and report like they should have."

On 8/28/14 at 2:10 pm, Z1, Primary Care Physician and Facility Medical Director stated the facility had not notified her of any inappropriate sexual behaviors regarding R16 prior to 8/26/14. Z1 stated that R15 has some cognitive impairment but R15 knows absolutely what he is doing.

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S9999	Continued From page 9 On 8/29/14 at 12:10pm E44, Corporate Administrator stated that E1 lacks the education and training in facility administration and E1 needed additional training. On 8/29/14 at 1:00 pm E44 also stated that E1 has only been an administrator for three months and "really doesn't know what she is doing yet." (A) 300.510e) 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.1220b)2) 300.1220b)3) 300.3240a) 300.3240d) 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	S9999		

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the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.
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 300.1220 Supervision of Nursing

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S9999	Continued From page 11 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. These requirements were not met as evidenced by: Based on observation, interview and record review the facility was not administered in a manner to identify and prevent a side rail entrapment hazard for R24, the facility failed to	S9999		

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comprehensively assess R24 for potential side rail entrapment and implement safety interventions to prevent entrapment while in her bed, and the facility failed to execute policies in a way to protect R24 from bed rail entrapment and subsequent injury. R24, one of five residents reviewed for falls in the sample of ten, became entrapped in the side rail, became hypoxic and sustained a neck injury. Administration had knowledge of and knowingly failed to report the incident, willfully omitted the nature and outcome of the incident when reporting to the attending physician, failed to ensure staff were trained on fall prevention, equipment safety, investigation/ root cause analysis, and development of targeted interventions to keep R24 and other at risk residents including R8, R13, R16, R31, R36 and R39 safe. Administration failed to provide oversight management to ensure at risk residents were monitored for safety, that staff were knowledgeable regarding their functional responsibilities and the operating policies related to the use of side rails were carried out. R8 and R13 are two of ten sampled residents. R16, R31, R36 and R39 are on the supplemental sample.

Findings include:

The Facility Abuse/Neglect Policy dated 2011, documents that the facility desires to prevent neglect by establishing residents with a secure environment. Through the care planning process staff will identify any problems, goals and approaches which would reduce the chances of neglect.

On 8/28/14 at 5:00 pm E2 Director of Nursing (DON) stated " I don't have any other fall or side

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rail inservices."

"Fall Management Program" inservices 10/16/13 signatures do not include E23, E34, or E33 Certified Nursing Assistants who worked the evening and night shifts of 5/31/14.

R24's Physician Order Sheet (POS) dated August 2014 documents the following diagnoses: Vascular Dementia, Dementia with Behavioral Disturbance, Depression, Paralysis Agitans, Other Convulsions, Edema, Difficulty Walking, Muscular Wasting and Disuse Atrophy. The POS has no documentation for the use of side rails.

R24's Minimum Data Set (MDS) dated 3/11/14 documents that R24 as having severe cognitive impairment, requires extensive assist of one staff for bed mobility, only able to balance between the bed and chair with staff assistance, and has had two or more falls since admission.

R24's Fall Risk Assessments dated 11/21/13, 2/22/14, 3/11/14, 5/17/14, 6/1/14, 6/11/14 and 8/20/14 document that R24 is at high risk for falls, with a history of falls. R24's Side Rail Assessment dated 11/12/13 documents that R24 has an increased risk for safety if side rails are used. R24's Side Rail Assessment dated 8/28/14 documents that R24's small stature, with space between the side rail and mattress, increase the risk to R24 safety with the right side rail discontinued and implementation of a bed bolster. On 9/5/14 at 9:35 am E8, Licensed Practical Nurse (LPN) acknowledged that the increased safety risk on these assessments is entrapment if side rails are used for R24.

R8, R13, R16, R31, R36 and R39's Fall Risk Assessments dated 8/6/14, 6/26/14, 7/23/14,

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S9999	Continued From page 14 8/9/14, 7/10/14, 7/30/14 and 7/30/14 respectively all document that these resident are at high risk for falls. On 8/28/14 at 12:00 pm R8, R13, R16, R31, R36 and R39 all had the same foam mattresses and side rail arrangements as R24. E7, Maintenance Director measured the gap from the bottom of the side rail to the top of the mattress at one and one half inches, without the weight of compression. There was also a gap of three and a half inches between the side of the side rail to the foam mattress. R24's Care Plan was updated on 11/11/13, 3/11/14 and 5/17/14. Each update documents that R24 is at risk for falls with a history of falls. These same updates do not address bed mobility or any new intervention or safety precautions to be implemented for three falls out of bed, on 2/22/14 at 1:30 pm, 2/22/14 at 4:00 pm and 5/17/14 at 7:30 am. R24's Care Plan was again updated 6/1/14 following another fall out of bed on 6/1/14 at 1:00 am, with an intervention to apply a zip tie to the bed side rail and bolsters to R24's bed. R24's Physical Therapy Plan of Care dated 2/16/14 documents R24's Bed Mobility as: Rolling, moderate ability. R24's Fall Detail Reports document the following falls: On 2/22/14 at 1:30 pm R24 was found on the floor, lying on (R24) stomach and was put back to bed. On 2/22/14 at 4:00 pm R24 was lying on R24 back on the floor next to (R24) bed. On 5/17/14 at 7:30 am R24 was found sitting on the floor next to (R24) bed. On 6/1/14 at 1:00 am the report documents that the bed alarm was not sounding when R24 was found on the floor with her neck caught under the side rail, was blue in color and not breathing.	S9999		

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R24's 6/1/14 fall with injury was not reported to Illinois Department of Public Health.

The facility's follow up reports for these falls document that no investigation or care plan updates are applicable.

R24's Nurses Notes on 6/1/14 at 1:30 am document R24's fall and that R24 did not breathe on her own until 15 seconds after E23 and E34 Certified Nursing Assistants (CNA's) transferred R24 from the floor to bed. The same Nurses Note documents that R24 had red indentation marks on the front of (R24's) neck when the night shift found R24 trapped under the side rail with no bed alarm sounding. The nurses notes are signed by E27, Licensed Practical Nurse (LPN).

The Emergency Department Report dated 6/1/14 documents R24 was evaluated, treated and released back to the facility with a diagnosis of a Neck Strain and an order given to follow-up with R24's primary care physician.

On 8/26/14 at E2 Director of Nursing stated " we don't have a fall policy."

The Facility Policy "Falls Post - Fall Protocol" by E1 Administrator and E2 Director of Nursing dated as revised 8/26/14 documents that the facility is obligated to investigate and try to determine how he/she got there (fell), and put into place an intervention to prevent this from happening again.

On 8/28/14 at 12:00 pm, E7, Maintenance Director measured R24's side rail gaps at one and a half inches between the foam mattress and the bottom of the side rail without the weight of compression. There was a gap of three and

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one half inches between the side of the side rail to the foam mattress. Identical foam mattresses and side rail arrangements were identified for six other residents R8, R13, R16, R31, R36 and R39 who are also at high risk for falls. E7 stated that he had zip tied R24's left side rail but someone broke it so E7 removed that rail. E7 stated that no one ever said anything about removing the right side rail until 8/28/14..

On 8/28/14 at 12:55 pm, R24 was not in her bed. There was a low bed with an upper 1/2 side rail on the right side of the bed. No bed bolsters were present on the bed, in the room or the closet.

On 8/28/14 at 2:40 pm Z1, Primary Care Physician/Medical Director stated "I was not aware of the incident involving (R24's) neck being caught in the side rail. I would have seen (R24) immediately even though (R24) was seen in the emergency room. I did receive a fax on 6/4/14 asking if I would see this resident for a fall follow up. I was not informed of this or any other injury related to that fall and I do not think it is safe for (R24) to have the other side rail remaining on her bed. The bolster order was not requested until 6/26/14 by fax and was given at that time."

On 8/28/14 at 3:10 pm E30, CNA stated "(R24) can move herself in bed with very little assistance."

On 8/28/14 at 4:05 pm E17, CNA and E30, CNA transferred R24 to bed and pulled up the right upper side rail to the highest position then did not put on bed bolsters as the care plan directs. At 4:10 pm E17 and E30 left the room and stated that they were finished with R24's transfer and had to answer another call light.

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On 8/28/14 at 4:12 pm while under constantly observed R24 repositioned herself to face the left side of the bed. At 4:15 pm E2, Director of Nursing (DON) stated she did not see a problem because the bed was in the low position. When the surveyor asked about the bolsters documented on the care plan for R24, E2 acknowledged the bolsters should be on the bed for safety. At 4:20 pm E17 stated "I started 6/5/14 and the bolsters were only on (R24's) bed that first night and there has not been bolsters on her bed since."

On 8/28/14 at 3:20 pm E8, Licensed Practical Nurse (LPN) / Care Plan Coordinator/ Minimum Data Set Coordinator stated "I have logged the falls and incidents but I did not know I was responsible to investigate them." On 8/28/14 at 3:35 pm E2 Director of Nursing (DON) stated "I have not investigated any falls since I started in March."

On 8/29/14 at 3:45 pm , E27 stated a E33, CNA on second shift left without doing final rounds on E33's assigned residents which included R24. E27 stated that R33 was supposed to turn on R24's bed alarm and monitor throughout the shift. E27 stated that the night shift first rounds R24 was found entrapped under her side rail and was not breathing. E27 acknowledged that R24 was blue in the face.

E33,Certified Nursing Assistants (CNA)'s Employee Disciplinary Action Report dated 6/5/14 documents a verbal warning for being informed multiple times for not doing walking rounds with the oncoming shift. E33 continued to work the evening shift on 6/1/14, 6/3/14, and 6/5/14 after the facility had knowledge of E33's refusal to do

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S9999	Continued From page 18 safety rounds on 5/31/14. On 8/29/14 at 1:00 pm E44, Corporate Administrator stated "I reviewed her (E33) file and saw she had a verbal warning for not doing rounds that night (6/1/14), she should have been terminated immediately.....(E1) is brand new three months as an administrator and really doesn't know what she's doing yet, that's why I am here for support." On 8/29/14 at 3:55 pm E2, Director of Nursing (DON) stated there is no policy that the facility gives as a job description to the Certified Nursing Assist (CNA) upon hire that include "rounds." The facility "Job Description 2nd Shift Certified Nursing Assistant" undated documents to "make sure all alarms are in place and call light within reach." The facility "Job Description 3rd Shift Certified Nursing Assistant" undated documents "before starting do a quick round to make sure all residents assigned to you are safe and comfortable. Make sure all alarms are on." The facility policy "Side Rails" dated as revised 1/23/13 documents " staff will weigh the probable effects of the use of side rails versus the effects of other intervention." The same policy documents that a consent will be obtained from the responsible party and a physician order will be obtained. There was no consent or physicians order in R24's medical record to have side rails. On 8/29/14 at 11:15 am E1, Administrator stated " no I did not report to public health because I didn't see there was any injury. (R24) revived (sta-ed breathing on her own) within 15 seconds	S9999		

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S9999	Continued From page 19 after being removed from the side rail. (R24) went to the hospital and there was no injuries (Neck Strain diagnosis on emergency room report) and returned to the facility the same night. I did not see this as a reportable." E44 stated "I am sorry apparently (E1) does not know what has to be reported to Illinois Department of Public Health. I will work with her on that." (A) Section 300.1230 Direct Care Staffing 300.1230 k) Staffing Effective September 12, 2012 a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. This requirement was not met as evidenced by the following: Based on record review and interview the facility failed to have 10% of nursing and personal care time provided by a Registered Nurse (RN) for 6 of 14 days reviewed. This has the potential to affect all 39 residents residing in the facility. Findings include: The undated spread sheet provided by E1, Administrator documents the period of time reviewed for staffing as 8/11/14 to 8/24/14. The spread sheet documents 1.79 skilled care residents and 37.50 intermediate care residents for that time period, which calculates to 100.55 hours of minimum required direct care staff. Ten percent of the total hours of direct care staff calculates to 10.05 hours of minimum Registered Nurse (RN) care required.	S9999		

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The spread sheet documents the following hours per 24 hour period for RNs:
8-12-14 - 7.75 RN hours
8-16-14 - 8.0 RN hours
8-17-14 - 8.0 RN hours
8-22-14 - 9.75 RN hours
8-23-14 - 8.0 RN hours
8-24-14 - 8.0 RN hours

The schedule dated August 2014 confirms the hours worked by RNs on those dates.

On 8/29/14 at 3:30 P.M. E1 Administrator, stated the RN hours listed on the spread sheet for each day are accurate.

According to the Resident Census and Conditions of Residents dated 8/25/14, 39 residents reside at the facility.

(B)

Resident Funds 300.3260 c)
The facility may accept funds from a resident for safekeeping and managing, if it receives written authorization from, in order of priority, the resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any; such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations, and who is not connected in any way to facility personnel or the administrator in any manner whatsoever. (Section 2-101(2) of the Act)

These requirements are not met as evidenced by:

Based on record review and interview the facility failed to ensure that resident trust fund authorization forms signed by residents with

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personal funds were witnessed by a non-employee for one resident (R8) reviewed with trust funds in the sample of 10 and five residents (R12, R36, R42, R43, R44), in the supplemental sample.
The findings include:
On 8/27/14 at 8:45 am the "Resident Personal Trust Fund Agreements" signed by residents to authorize the facility to accept money in the trust account were reviewed with Information Coordinator E6. E6 confirmed the following:
R8 signed an authorization on4/04/14, witnessed by E36 Admissions Marketing Director;
R12 signed an authorization on 3/31/14,witness by E36;
R42 signed an authorization on 8/01/14, witnessed by E36;
R43 signed an authorization on 10/23/13 without a witness signature;
R44 signed an authorization on 3/27/14, witnessed by E36.
R36 signed an authorization on 1/15/11, witnessed by former Office Manager E37.
The undated Resident's Personal Trust Fund Agreement form has a signature line for the Resident/Power of Attorney, a line for a Facility Representative and a line for a Witness which states "If resident signs, then a non-employee needs to witness."

(B)

Updated POC for {300.510e), 300.610a), 300.1210b), 300.12
300.1220b)2), 300.3240a), 300.3240b) & 300.324

F 224 (page 13)

300.510a), 300.610a), 300.1010b), 300.1210b), 300.120
300.1220b)2), 300.1220b)3), 300.3240a) & 300.3240d)

A.

1. Corrective Action Taken For Those Residents Found To Be Affected By Deficient Practice

As stated in the Statement of Deficiencies the facility took the following actions at the time of the survey: R 15 has been removed from the facility; the facility conducted interviews with each resident having the potential to be affected by R 15's conduct to identify any further allegations of abuse not reported; all staff members were inserviced on resident abuse and the need to report that abuse. The facility has taken the following action since the date of the survey. Facility office and nursing staff have been inserviced on the facility abuse policy including the requirement that all instances of possible abuse must be documented in the resident's records and be immediately reported to the Administrator, or to a supervisor who then must immediately report the incident to a supervisor, and to the resident's doctor and that documentation of that reporting must be made. The inservice emphasized that any facility staff member who sees an instance of possible abuse or who hears of an instance of possible abuse must report the incident and cannot rely on others to do so. The inservice further instructed facility staff that a failure to document and or report will result in discipline up to and including discharge. The Administrator and DON have been inserviced on the need to investigate and report as required each instance of possible abuse and further of the requirement that immediate steps must be taken to assure that any resident suspected of possible abuse is not left in a position to engage in further abuse pending the outcome of the investigation. In addition this inservice included the need to assess any resident suspected of abuse, the need to revise the resident's care plan with additional interventions to keep the resident from committing further instances of abuse, and the requirement that nursing staff must be inserviced on the revised care plan and the requirement that the revised care plan must be followed. The DON, Administrator and nursing staff have been inserviced that where supervision such as 15 minute checks has been ordered to assure that a resident cannot engage in further possible abuse, nursing staff must carry out that additional level of supervision and document that this is being done and that the DON, Administrator and Charge Nurses must follow up to ensure that this is being done by observing resident care and the documentation of the supervision. These inservices will be repeated on a monthly basis for the next three months and thereafter quarterly for the following three quarters. R 16, R 9, R 13, R 17, R 21, R 23, R 24, R 26, R 27, R 38, R 45, and R 46 as well as other residents at the facility are no longer at risk for sexual abuse.

2. Identification of Other Residents Having The Potential To Be Affected By The Same Deficient Practice

The facility has reviewed each resident and has identified any resident having the potential to abuse another resident. The facility has assessed each such resident and has reviewed and revised the care plan for each such resident with additional interventions and approaches designed to assure that abuse does not occur. Nursing staff have been inserviced on the care plan for each such resident and on the need to assure that the care plan is followed.

3. Measures Taken To Assure That Deficient Practice Does Not Reoccur

The facility has taken the following action since the date of the survey. Facility office and nursing staff have been inserviced on the facility abuse policy including the requirement that all instances of possible abuse must be documented in the resident's records and be immediately reported to the Administrator or to a supervisor who then must immediately report the incident to the Administrator or to a supervisor who must then immediately report to the Administrator and to the resident's doctor and that documentation of that reporting must be made. The inservice emphasized that any facility staff member who sees an instance of possible abuse or who hears of an instance of possible abuse must report the incident and cannot rely on others to do so. The inservice further instructed facility staff that a failure to document and or report will result in discipline up to and including discharge. The Administrator and DON have been inserviced on the need to investigate and report as required each instance of possible abuse and further of the requirement that immediate steps must be taken to assure that any resident suspected of possible abuse is not left in a position to engage in further abuse pending the outcome of the investigation. In addition this inservice included the need to assess any resident suspected of abuse, the need to revise the resident's care plan with additional interventions to keep the resident from committing further instances of abuse, and the requirement that nursing staff must be inserviced on the revised care plan and the requirement that the revised care plan must be followed. The DON, Administrator and nursing staff have been inserviced that where supervision such as 15 minute checks has been ordered to assure that a resident cannot engage in further possible abuse, nursing staff must carry out that additional level of supervision and document that this is being done and that the DON, Administrator and Charge Nurses must follow up to ensure that this is being done by observing resident care and the documentation of the supervision. These inservices will be repeated on a monthly basis for the next three months and thereafter quarterly for the following three quarters.

4. Quality Assurance

The Administrator, DON, Care Plan Coordinator and QA Committee (1)will on an ongoing basis review the care plans for all residents including those residents having the potential for

abuse of other residents to ensure that appropriate interventions and approaches are in place to prevent abuse from occurring, (2) will ensure that nursing staff are inserviced on the care plans and the need to follow the care plans for all such residents, (3) will on an ongoing basis review each instance of possible resident abuse to ensure that each instance has been investigated, documented, reported as required, and that all steps have been taken to prevent the possible abuser from undertaking further abuse both during the investigation and after the investigation completion if abuse was found.

B.

1. Corrective Action Taken For Residents Found To Have Been Affected By Deficient Practice

As stated in the Statement of Deficiencies, the facility took the following actions at the time of the survey: The side rails for R 24 have been removed and bolster pads are now in place, the side rails for R 8, 13, 16, 36, and 39 have been removed because they have been assessed as high risk for falls, the care plans for R 24, 8, 13, 16, 36, and 39 have been revised as needed with additional interventions and approaches based upon their assessment as high risk for falls, all other residents (R 23, R 25, R 27, R 37, and R 38) with the same side rail arrangements also had their side rails removed, The MDS Coordinator, DON, Maintenance Director, and Administrator were inserviced on the importance of side rail assessment and the expected benefits. The following additional steps have been taken since the date of the survey: (1) a policy has been established for CNA rounds including the requirement that all rounds must be conducted as scheduled and that CNAs must turn on bed alarms and monitor residents safety during rounds; (2) all CNAs have been inserviced on the round policy; (3) E 33 has been terminated; (4) The Administrator has been inserviced on the need to monitor CNAs and on whether they are performing rounds as required and that a failure of a CNA to conduct rounds as required should be considered as grounds for termination; (5) nursing staff including the DON have been inserviced on the facility fall policy including the requirement to investigate and document the investigation of each fall and to report each fall as required to the resident's doctor and to IDPH; (6) R 24 has been reassessed for falls with his/her care plan reviewed and revised with additional approaches and interventions to prevent falls; (7) nursing staff who care for R 24 have been inserviced on the residents revised care plan and on the need to follow that care plan; (8) The Administrator, DON and facility nursing staff have been inserviced on the facility side rail policy including the requirement for an assessment of each resident that weighs the probable effects of the use of side rails versus the effects of other interventions, the requirement that a consent be obtained from the responsible party and the requirement that a doctor's order must be obtained with the consent and order placed in the resident's medical record; (9) The facility has reviewed the chart for each resident to verify that the re`uired assessment, consent and order is in place; (10) The DON and facility nursing staff have been inserviced on the requirement that each instance of resident injury, resident fall, or injury from a fall must be reported to the

resident's doctor; (11) The facility has reviewed the charts for all residents for the last six months to verify that all instances of resident injury, resident falls, or injury from falls have been reported to the resident's doctor; (12) the Administrator has been inserviced on the facility abuse policy including the reporting requirements to IDPH.

2. Identification of Other Residents Having Potential To Be Affected By Same Deficient Practice

The facility has reviewed each resident with a side rail to verify that each such resident has been assessed, that a consent has been obtained and that order for the side rails has been received. The facility has reviewed each resident fall for the last six months to verify that the fall was investigated, that the resident was reassessed, that the resident's care plan was revised as needed with additional interventions and approaches to prevent future falls, that nursing staff were inserviced on the revised care plans and that the resident's doctor and IDPH was notified as required. For any fall where this did not occur, the facility will investigate the most recent fall or falls, reassess the resident, revise the resident's care plan as needed for additional interventions and approaches to prevent falls, inservice nursing staff on the revised care plans and on the need to follow the care plan, and notify the resident's doctor and or IDPH.

3. Measures Taken To Prevent Reoccurrence of Deficiency

The following additional steps have been taken since the date of the survey: (1) a policy has been established for CNA rounds including the requirement that all rounds must be conducted as scheduled and that CNAs must turn on bed alarms and monitor residents safety during rounds; (2) all CNAs have been inserviced on the round policy; (3) E 33 has been terminated; (4) The Administrator has been inserviced on the need to monitor CNAs and on whether they are performing rounds as required and that a failure of a CNA to conduct rounds as required should be considered as grounds for termination; (5) nursing staff including the DON have been inserviced on the facility fall policy including the requirement to investigate and document the investigation of each fall and to report to the resident's doctor and or IDPH ; (6) R 24 has been reassessed for falls with his/her care plan reviewed and revised with additional approaches and interventions to prevent falls; (7) nursing staff who care for R 24 have been inserviced on the residents revised care plan and on the need to follow that care plan; (8) The Administrator, DON and facility nursing staff have been inserviced on the facility side rail policy including the requirement for an assessment of each resident that weighs the probable effects of the use of side rails versus the effects of other interventions, the requirement that a consent be obtained from the responsible party and the requirement that a doctor's order must be obtained with the consent and order placed in the resident's medical record; (9) The facility has reviewed the chart for each resident to verify that the required assessment, consent and orde - is in place; (10) The DON and facility nursing staff have been inserviced on the requirement that each instance of resident injury, resident fall, or injury from a fall must be reported to the resident's doctor; (11) The

facility has reviewed the charts for all residents for the last six months to verify that all instances of resident injury, resident falls, or injury from falls have been reported to the resident's doctor; (12) the Administrator has been inserviced on the facility abuse policy including the reporting requirements to IDPH.

4. Quality Assurance

The Administrator, DON and QA Committee will undertake the following steps to ensure that this plan of correction is followed: (1) monitor during regular rounds CNAs to ensure that the round policy is being followed and that CNAs are checking during rounds on resident safety and that all bed alarms are turned on; (2) monitor each resident fall to ensure that all falls are documented, investigated, reported to the resident's doctor with follow up assessment, revision of the care plan and inservice of nursing staff on the revised care plan; (3) monitor the implementation of the facility side rail policy including verifying that there is an assessment, consent and order in place for any side rails in use; (4) monitor each fall or resident injury to ensure that reports are made as required to the resident's doctor; (5) ensure that each instance of accident ~~or injury are~~ reported to IDPH as required.

Completion Date: 09/30/14

accepted