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	14G295	A. BUILDING _____ B. WING _____	C 01/11/2007

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ADLOFF PLACE	50 ADLOFF LANE SPRINGFIELD, IL 62703

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W 157	Continued From page 33 Per review of the Incident Management Committee meetings discussion notes (Section 5 of the Individual Unusual Incident Report), of 11/8, 11/13, 11/17, 11/28, 12/7, 12/12, and 12/15 corrective actions were never taken by the facility to prevent R1 from multiple bruise injuries, pain and hospitalization of 12/16/06 from frequent falls.	W 157		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based interview and record verification the facility did not provide nursing services in accordance with the needs of 1 of 3 in the sample (R1) Findings include: The facility neglected to assess R1's injuries in a timely manner, document those injuries and provide nursing follow-up assessment of those injuries. (E2, E21) Cross refer to W122, W149, W154, W157.	W 331		2/2/07
W9999	FINAL OBSERVATIONS REPEAT TYPE "A" VIOLATION Section 350.620a) Section 350.620b)6) Section 350.700a)1) Section 350.700a)2) Section 350.700b) Section 350.700c) Section 350.3240a)	W9999		

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W9999	Continued From page 34 Section 350.3240b) Section 350.3240c) Section 350.3240d) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, resident records, dental services, and diagnostic service (including laboratory and x-ray). Section 350.700 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each serious accident	W9999		

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W9999	Continued From page 35 or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurses' notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 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) These Regulations are not met as evidenced by: Based on observation, record review and interview the facility to comply with its Plan of correction from the 8/1/06 survey by failing to (1) ensure that staff reported unusual incidents and suspected abuse in a timely manner, (2) ensure that all injuries of unkown origin are investigated, (3) ensure that all injuries are documented on an incident report form, and (4) ensure that residents who are the possible victims of physical abuse are immediately examined by a nurse and/or	W9999		

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W9999	Continued From page 36 physician. The facility failed to implement their policy/procedure to prohibit neglect, failed to implement their policy/procedure for reporting individual unusual incidents, and neglected to safeguard and protect 1 of 3 individuals in the sample (R1) who has sustained multiple bruise injuries, pain and hospitalization. In addition R1 was found with an injury/bruise suspicious of sexual assault and one shaped in a fist pattern. Findings include: Individual Support Plan (ISP) dated 10/17/06 and Physician Order Sheet (POS) of 11/20/06, identifies R1 as a 35 year old ambulatory verbal female. This ISP states "R1 is verbal and responds to questions. She comprehends what is asked, although she does not always respond appropriately. The staff report that R1 will let them know if she enjoys an activity by her body language and gestures. If she is not enjoying an activity, she will sit on the floor and refuse to move." This ISP further states that R1 has the diagnosis of Profound Mental Retardation (MR), Autism, Schizoaffective Disorder, History of Tuberculosis (TB), Seizures, Tourette Syndrome, Hypertension, Irregular Menses and Tardive Dyskinesia. Per review of incident reports (IR), from 11/06/06 through 12/21/06, and Nurse's Notes (N.N.) 10/31/06 through 12/16/06, R1 had the following documented falls and injuries: IR of 11/5/06 10:30AM, R1 was hit by an	W9999		

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W9999	Continued From page 37 unidentified individual and then grabbed and shoved to the floor while walking past the individual. Bruise noted to lower left buttocks. IR of 11/6/06 7:25PM, "huge bruise on her left leg. It seems to have a indentation of a hand or fist and a scratch directly below it." IR of 11/6/06 10:12PM, additional bruises found on legs, bruise left buttocks area, bruise located below right buttocks and lower calf. IR of 11/11/06 2:00PM, 1.5" scratch and .5 cm. bruise on right posterior shoulder. IR of 11/17/06 7:50AM, hit on the right side of her face, by an unidentified resident who came into her room while she was lying in her bed. No apparent injury. N.N. of 11/20/06 2:20PM, R1 noted to have "very large bump--size of two golf balls, palpable with some firmness" on neck. Dr. Z5 called. Z5 instructs the Director of Nursing (DON), E2, to observe lumps for change. N.N. of 11/23/06 10:30PM, DON, E2 called at home, resident was having some tremors, mouth twisted and speech slurred. On arrival R1's vital signs stable, left eye slightly red, resident complained of being tired and wanted to go to sleep. On call physician, Z12, called by E2, gave no new orders. IR of 11/24/06 7:41AM, 2 dime size bruises found on R1's mid back purplish yellow in color and 1.5" friction rub on right buttocks at gluteal crease.	W9999		

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W9999	Continued From page 38 N.N. of 11/26/06 4:00PM, bruise noted to right inner thigh to the side of vagina. "Vagina area red with foul odor present. Thick yellow drainage noted coming from vagina." Dr Z5 notified per fax. No response identified from the physician and no follow up noted by the nurse in the N.N.. Per gynecologic cytology report of 12/8/06 and backdated N.N of 12/8/06, R1's pap results were normal. The facility can not find an IR of this unknown injury. There is no facility investigation of this 11/26/06 bruise injury of unknown origin suspicious of sexual assault. IR of 12/4/06 9:02PM, bumped toe on entrance to her bedroom, no apparent injury. IR of 12/6/06 8:30PM, 3.5 inch redden bruise to right inner thigh, right hip and bilateral knees. IR of 12/10/06 7:10AM, R1 came into front room, looking tired, missed the chair fell and bumped the back of her head on the front door of the facility. (Per staff communication log R1 was up all night and was restless on the second shift of 12/9/06.) Nurse assessment completed 5 days later identified no injury. There is no evidence of a nursing neurological assessment completed as per facility policy number P-500.07.1. for Head Injuries. Per ISP of 10/17/06 R1 has a history of seizures. The DON, E2, stated, per 10/21/06 12:25PM interview, that R1 has not had a neurological evaluation since she has been working at the facility. R1's record per review contains only one neurological assessment (12/16/06) since her admission to the facility on 9/6/05. IR of 12/11/06 2:40, at current DT, R1 appears drowsy and while attempting to sit in chair fell to	W9999		

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W9999	Continued From page 39	W9999		

her right hitting her right shoulder and right hip. No injury is identified on DON E2's assessment of R1, completed upon her returned to the facility from the DT site.

IR of 12/12/06 10:30AM, DON E2 called to DT site, bruising, swelling and hardness to resident's left buttocks. Dr. Z5 notified of injury and instructed E2 to observe. Per Section 2 of IR completed by shift lead staff E12, R1 fell while staff were trying to get her on the van for an appointment with the psychiatrist, Z7. Z7 reduced R1's medications at the appointment as follows.

Per POS of 11/21/06 and ISP of 10/17/06, R1 was routinely taking Depakote ER, Toprol XL and Chlorpromazine for her Schizoaffective Disorder, Benztropine for Tardive Dyskinesia diagnosis and Low-Ogestrel-28 for irregular menses until 12/12/06. After psychiatric visit with Z7 on 12/12/06, R1's medications Benztropine was discontinued and the medications Depakote and Thorazine were reduced.

N.N. of 12/13/06 (back note of 12/12/06) states that DON E2 was called by staff at home, R1 lethargic and another bruise noted on posterior left leg. R1 taken to local emergency room (ER). R1 returned to the facility with physician orders from Z6 "to rest, fall precautions at the group home, take Tylenol or ibuprofen for pain, see your MD in 5-7 days for recheck."

It was confirmed by DON E2's (12/28/06 12:30PM) and QMRP E3's (12/28/06 11:10AM) interviews that neither E2 nor E3 saw the physician orders from the 9:21PM ER visit of 12/12/06 and fall precautions for R1 were not

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W9999	Continued From page 40 initiated by the facility as ordered. IR of 12/13/06 7:00PM, while standing and having face wiped and clothing protector removed by staff, R1 fell back onto a wheelchair and scratched her back. The DON, E2, assessed R1 the next day 12/14/06. R1sustained a 3" raised abrasion to mid back and 10 inch raised abrasions to top of vertebra. N.N. of 12/14/06 6:30PM for R1 states: "up per usual routine. Will continue to monitor." IR of 12/15/06 12:35 from DT site states R1 dropped to the floor from a height on 1-1 1/2 feet when attempting to sit on the floor. N.N. of 12/15/06 4:40PM states resident ambulatory with unsteady gait. Medications reduced. Resident less lethargic. IR of 12/15/06 6:30PM R1 tripped and fell landing on her right side, no apparent additional bruising at this time. IR of 12/16/06 10:45AM, resident was in the day room. Got up out of the rocking chair. Walked over to another chair and fell backwards, old bruises noted. N.N. of 12/16/06 11:00AM, resident up and down all morning. Has dropped to the floor several times this AM. IR of 12/16/06 (time not identified) resident was getting up from the table with assistance of DON, E2, and R1 slipped in some juice on the floor. R1 and the DON both slipped and fell to the floor. R1 hit right side of face. R1's right side of mouth	W9999		

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W9999	Continued From page 41 bleeding and right cheek bruised. a) Staff neglected to implement facility policy of reporting unusual incidents and suspected abuse of R1. (E7 neglected to immediately contact the nurse, E20 neglected to immediately contact and advise the Administrator of the situation.) Per review of Unusual Incident Report of 7:25PM on 11/6/06, it was identified that R1 was found with "a huge bruise on her left leg." Staff E7 writes on this report that the bruise seems to have the indentations of a hand or fist and that there is a scratch below the bruise. E7 further writes that the "bruise looks entirely new because it was not present last night (11/5) when I dressed her for bed." E7 also writes on this report that the shift lead and two other staff saw the bruise. E7 stated, per 12/27/06 2:47PM phone interview, that she thought the bruise was suspicious of abuse and informed her shift lead E20. E7 further stated that she recently completed her habilitation training (hired 9/2/06) and had been "trained to go through the chain of command." E7 stated she thought E20 would report it. E20, the shift supervisor documented in section 2 of this incident report the following: "We did a body check on the individual to see if there were other injuries that wasn't discovered, there wasn't anymore at this point. Nurse had already left for the evening. Will ask her to assess tomorrow." Second Unusual Incident Report of the same	W9999		

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W9999	Continued From page 42	W9999		

evening of 11/6/06 states that at 10:12PM, additional bruises were found on R1's legs, one bruise located on her left buttocks area, other bruises located on R1's right side below her buttocks and another bruise located on her lower calf. This report again by E7 states that the bruises are very new, still purple and were showed to E7's shift lead E20.

E20, on this second incident report of the same evening of 11/6/06, documented that staff found more bruises after doing a body check the first time and that the nurse will be asked to assess tomorrow.

The facility's policy for Reporting Individual Unusual Incidents, Operating Procedure Number 0-300.04.1, revised 8/5/06 states the following:

"DDMS managed facilities shall ensure that staff are aware of their responsibilities regarding identifying, reporting, managing and resolving all Individual Unusual Incidents involving individuals to ensure that all individuals are safe and protected from harm."

This policy further states under PROCEDURE: 1., that if the unusual incident involves suspected abuse, neglect, or mistreatment of an individual or results in serious injury that the staff are to immediately inform the nurse, then inform their supervisor and then complete Section 1 of 0:300.04.1-A (Individual Unusual Incident Report Form). This policy further states that the supervisor shall immediately contact and advise the administrator of the situation and complete Section 2 of the Form 0:300.04.1-A.

E7 did not inform the nurse as per policy. E7

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W9999	Continued From page 43 stated, per 12/27/06 phone interview, that she was trained to go through the chain of command and reported the suspicion of abuse to her shift lead (E20). E7 further stated that she thought E20 would notify the administrator. E20 stated, per 1/10/07 8:38AM phone interview, "That night (11/6/06), I did not know what to think. I was thinking somebody was beating her up (R1)." E20 further stated that she did not call the administrator and that the nurse was already gone for the evening. E20 stated that she was trained to fill out the report and put it in the (locked) box. Personnel File review and confirmed by E3's 12/21/06 10:15AM interview, it was determined that E20 was terminated from employment on 12/5/06 for an unrelated issue of neglect. b) Nursing neglected to assess R1's injuries ie, fist bruise of 11/6/06, an unusual injury suspicious of abuse near R1's vaginal area of 11/26/06 and multiple bruise injuries of know and unknown origin in a timely manner, document those injuries and provide nursing follow-up assessment for those injuries. The 5:30PM Nurse's Note (N.N), 11/7/06, (following the bruise injuries of 11/6/06) by the evening License Practical Nurse (LPN) E21, states that E21 was given the incident report on R1 and documented that the resident had a 6 1/2 in length by 3" in width palpable bruise to her left thigh. This N.N. further states that R1 voiced no complaint of discomfort or pain and that staff stated the bruise was not there on 11/5/06. E21 also documents in this N.N. that the	W9999		

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W9999	Continued From page 44 Qualified Mental Retardation Professional (QMRP), E3, will notify R1's family; that at 6:00PM the Director of Nursing (DON) was notified of the injury; and at 6:15PM Dr. Z5 was notified by Fax and per voice mail. According to this N.N., Dr Z5 returned E21's call and gave no new orders. The facility's policy, on reporting individual unusual incidents (0-300.04.1) procedure 1. C., states: "The nurse shall, in cases where an unusual incident results in injury, attend to the injured and complete Section 3 of the Form 0:300.04.1-A Individual Unusual Incident Report. Per review of R1's incident reports, of 11/6/06 at 7:25PM and 10:12PM, the next evening 11/7/06, LPN E21 documented, on Section 3 of the report, different findings on her assessment of R1's injuries as follows: 1) On the incident report of 11/6/06, 7:25PM, E21 documents "Purplish bruise noted to residents L (circled) thigh. Voices 0 (with a line through it) C/O (complaints) of pain or discomfort when area is assessed." 2) Incident report at 10:12PM on 11/6/06, E21 writes "Bruises noted to residents L (circled) hip area" and indicates with an up and down arrow of bruises on upper and lower buttocks. According to QMRP E4,12/28/06 11:10AM interview, the DON, E2, worked the day shift of 11/7/06 and indicated that she had no idea why R1 was not assessed the next day by E2. E4 further stated that the nurses are suppose to check the locked box daily. E4 stated that this is where the IR's are kept.	W9999		

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W9999	Continued From page 45 DON E2 stated, per 12/28/06 12:30PM interview, that she never saw the 11/6/06 incident reports until two days later when the Incident Management Committee (IMC) met on 11/8/06. It is only at this IMC meeting, attended by E1, E2, E3 and E20, per review of clinical record and IMC discussion notes, that it was first determined that R1's multiple bruises 11/6/06 and alleged huge bruise from a hand or fist needed to be investigated. Nursing neglected to assess R1's unusual injury suspicious of abuse near R1's vaginal area of 11/26/06. N.N. of 11/26/06 4:00PM, bruise noted to right inner thigh to the side of vagina. "Vagina area red with foul odor present. Thick yellow drainage noted coming from vagina." Dr Z5 notified per fax. No response identified from the physician and no follow up noted by the nurse in the N.N.. Per gynecologic cytology report of 12/8/06 and back dated N.N. R1's pap results were normal. Per 11/21/06 POS, R1 takes birth control medication Low-Ogestrel-28 daily for irregular menses. Confirmed by 1/2/06 phone interview with the QMRP, E3, R1 has menses. E3 stated that E1, the home manager stated R1 has regular menses. The Annual Menses Record documentation for 2006 identifies that R1 has had only one scant menses on 10/20/06. Per review of incident reports (IR) from 11/06/06 through 12/21/06, and Nurse's Notes (N.N.) 10/31/06 through 12/16/06, there is no documentation of any nursing follow-up assessment to any of R1's injuries including review of R1's mensses records following the	W9999		

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W9999	Continued From page 46 injury to R1's vaginal area on11/26/06. c) The facility neglected to have evidence of thoroughly investigating R1's 11/06/06 bruises of unknown origin, alleged to be in the shape of a fist. The facility's investigation, initiated on 11/8/06 after IMC meeting and completed on 11/15/06, of R1's 11/6/06 bruises was not thorough (the facility neglected to interview Day Training (DT) staff as per policy) and the facility neglected to complete their investigation in the 5 day required time frame. The facility neglected to investigate R1's 11/26/06 injury of unknown origin that appeared suspicious of sexual assault. Per QMRP E3, 12/26/06 11:00AM and 12/28/06 interviews, and confirmed by the facility's 11/15/06 fax cover sheet, the facility's investigation summation of R1's 11/6/06 injuries concluded that they occurred at her former DT. E3 concluded this because bruises take awhile to appear. E3 stated that she was unable to get information from the former DT, that she did not go over to the DT site but that they did not respond to her inquiry. E3 stated that R1 is now attending a new DT. Per the facility's ABUSE AND NEGLECT 0-300.04.2, PROCEDURE 5. "The facility Administrator or designee shall ensure that all injuries of unknown origin are investigated. In situations involving minor injuries of unknown origin where the injury is not suspicious due to the extent of the injury or the location of the injury, the investigation shall	W9999		

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W9999	Continued From page 47 include but not be limited to:": Interviews with the following are listed: A. staff discovering injury, B. staff working shift injury discovered, C. staff who worked the previous shift. Procedure 5. D. of this policy states: "Conduct an interview with the responsible staff person at the Day Program facility if applicable;". The facility neglected to have evidence of thoroughly investigating R1's 11/6/06 injuries of unknown origin by neglecting to interview R1's former and current DT staff. It was confirmed by review of the facility's investigation summary and 12/26/06 interview with E3, the facility's investigation of R1's 11/6/06's injuries of unknown origin was initiated on 11/8/06 after the IMC meeting and two days after injury, and completed on 11/15/06. This investigation was not completed within the required 5 day time frame. There is no facility investigation of R1's 11/26/06 bruise injury of unknown origin suspicious of sexual assault nor is there an IR report of the following Nurse's Note (N.N.). N.N. of 11/26/06 4:00PM, bruise noted to right inner thigh to the side of vagina. "Vagina area red with foul odor present. Thick yellow drainage noted coming from vagina." Dr Z5 notified per fax. No response identified from the physician and no follow up noted by the nurse in the N.N. Per gynecologic cytology report of 12/8/06 and back dated N.N., R1's pap results were normal.	W9999		

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W9999	Continued From page 48 d) The facility neglected to take corrective action following the incident of the alleged bruise in the shape of a fist, the alleged sexual abuse and the multiple bruises of known and unknown origin. There is no evidence of reassessments, no evidence of tracking and no changes in R1's level of supervision or Individual Support Plan. The facility neglected to take corrective action for R1's frequent falls, and neglected to follow physician orders, of 12/12/06 emergency room visit, to provide "fall precautions at the group home" for R1. The facility neglected to have evidence and ensure that all injuries of unknown origin are investigated and neglected to track and identify patterns and trends of all injuries of unknown origin as per ABUSE AND NEGLECT operating procedure number 0.300.04.2. The facility's ABUSE AND NEGLECT operating procedure number 0.300.04.2. states the following: "5. The facility Administrator or designee shall ensure that all injuries of unknown origin are investigated. In situations involving minor injuries of unknown origin where the injury is not suspicious due (to) the extent of the injury or the location of the injury, the investigation shall include but not be limited to:": Interviews with the following: A. staff discovering injury, B. staff working shift injury discovered, C. staff who worked the previous shift. D. the responsible staff person at the Day Program facility if applicable. E. interview nurse, van driver anyone that might be able to provide information. F. review facility's communication log and any nursing notes. G. Review the bed check logs. H. Summarize this	W9999		

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W9999	Continued From page 49 information in section 5 of FORM: 0-300.04.1-A, Individual Unusual Incident Report. I. Input all Individual Unusual Incident Report information into the Incident Management Trending Tool, Form 300.04.1-A in an effort to identify any patterns or trends that will aid in the prevention of future incidents. If a trend or pattern of 4, 5, or 6 injuries of unknown origin surfaces, the Administrator or designee shall notify IDPH within 24 hours and launch a full investigation according to Operating Procedure 0--300.04.3, Investigation of Abuse and Neglect. The facility has no evidence of investigating the following injuries of unknown origin for R1: 1) IR of 11/11/06 2:00PM, 1.5" scratch and .5 cm. bruise on right posterior shoulder. 2) N.N. of 11/20/06 2:20PM, R1 noted to have "very large bump--size of two golf balls, palpable with some firmness" on neck. Dr. Z5 called. Z5 instructs DON, E2, to observe lumps for change. 3) IR of 11/24/06 7:41AM, 2 dime size bruises found on R1's mid back purplish yellow in color and 1.5" friction rub on right buttocks at gluteal crease. 4) N.N. of 11/26/06 4:00PM, bruise noted to right inner thigh to the side of vagina. "Vagina area red with foul odor present. Thick yellow drainage noted coming from vagina." Dr Z5 notified per fax. No response identified from the physician and no follow up noted by the nurse in the N.N.. Per gynecologic cytology report of 12/8/06 and back dated N.N of 12/8/06. R1's pap results were normal. Per 11/21/06 POS, R1 takes birth control medication Low-Ogestrel-28 daily for irregular menses. Confirmed by 1/2/07 phone interview with the QMRP, E3, R1 has menses. E3 stated that E1,	W9999		

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W9999	Continued From page 50 the home manager stated R1 has regular menses. The Annual Menses Record documentation for 2006 identifies that R1 has had only one scant menses on 10/20/06. Facility cannot find an IR of this unknown injury. Confirmed by 1/11/07 2PM exit conference interview with E2,E3 and E4 the facility cannot find this IR. 5) IR of 12/6/06 8:30PM, 3.5 inch reddened bruise to right inner thigh, right hip and bilateral knees. The QMRP E3, per exit conference interview of 1/1107 2:35PM, stated that she does investigate injuries of unknown origin but had no investigations for the above listed injuries because they knew R1 was falling. The facility's policy states that "all" injuries of unknown origin are to be investigated. The facility neglected to track and identify all injuries of unknown origin Per review of the facility's November 2006 Incident Management Trending Tool, Form 300.04.1-A, the following Incident Reports are not included. 1) IR of 11/6/06 7:25PM, "huge bruise on her left leg. It seems to have a indentation of a hand or fist and a scratch directly below it." 2) IR of 11/6/06 10:12PM, additional bruises found on legs, bruise left buttocks area, bruise located below right buttocks and lower calf. The facility neglected to take corrective action. Per review of incident reports (IR) from 11/06	W9999		

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W9999	Continued From page 51 through 12/21/06, and Nurse's Notes (N.N.) 10/31/06 through 12/16/06, R1 had multiple documented falls and injuries. Per review of the Incident Management Committee meetings discussion notes (Section 5 of the Individual Unusual Incident Report), of 11/8, 11/13, 11/17, 11/28, 12/7, 12/12, and 12/15, corrective actions were never initiated by the facility to prevent R1 from sustaining multiple bruise injuries, pain and hospitalization of 12/16/06 from these frequent falls. Per 12/21/06 12:25PM interview with the DON, E2, R1 was sent to the hospital 12/16/06 at 6:30PM for a change of condition. E2 further indicated that R1 was ambulatory and having lots of falls. Ambulance report of 12/16/06 7:23PM states "the main reason they (facility nurse) want her (R1) checked out is because she has been acting different since they switched her meds x 2 days ago. They state she likes to throw herself around which is not like her." The ambulance's arrival time at local hospital ER, per report was 7:33PM. Local hospital physician, Z16, admitted R1 with a diagnosis of multiple bruises and mental status change. Z16 admission history and physical states the following: "The person (E10 from the facility) who is with her (R1) tonight states that she has not been with her for the past several days but her mental status has markedly changed." This report also states that R1 was taken to a gynecologist a week and a half or two weeks ago, because of bruising on her interior thighs, and there was a	W9999		

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W9999	Continued From page 52 question of her having had some molestation. Z4, the social worker from the local hospital per 12/21/06 phone interview, stated that the facility's direct care staff E10 came to the hospital and stayed with R1 until her admission. Per 12/27/06 3:18PM phone interview, E10 stated that she informed E2 that she suspected R1 was being abused but did not recall when she informed E2. E10 further stated that the facility investigated it. There is no evidence of this investigation. E2, the DON stated at 1/11/07 exit conference interview that no one has ever stated to her that they suspected abuse. Z16's physical exam "reveals an awake, but clearly not meaningful responsive, white female who was clearly uncomfortable when attempts were made to move her. We were able to examine her mouth and teeth. She had some bleeding about her gums and her lip. She had bruising over both shoulders. She had shallow abrasions, almost looked like rug burns along her thoracic spine process, probably second through fifth perhaps. I could not get her to sit up anymore because she became so uncomfortable she fought to have that done. We were able to examine her breasts. She had seemed to have an unusual shaped lesion on the lower part of the right breast. There was an unusual mark on her right wrist." The physical exam of R1's extremities further states both the shoulder areas and posterior shoulders, especially on the left, had ecchymoses. There were ecchymoses on the left upper arm. There was a rather large area of ecchymoses, and some swelling associated with	W9999		

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W9999	Continued From page 53 the left buttocks, and left posterior thigh to the knee, on both lower extremities. There were anterior abrasions on both knees. There were some other marks and bruises. Numerous marks and bruises on her anterior and posterior aspects of both lower extremities. The ER physician Z16 impression from this physical exam was the following: "Mental status change. Multiple bruises and abrasions. Certainly, considering the place where she lives, must consider some potential for abuse being the reasons for these things. The patient has been admitted for evaluation of her mental status change and to evaluate her injuries." Per 12/21/06 2:48PM observation of R1's injuries and review of hospital photographs of those injuries, the surveyor was able to confirm Z16's physical exam findings. Z8, the guardian of R1, per 12/27/06 2:05PM phone interview, stated that the facility did inform her of R1's bruises but that she had "no clue of the intensity of the bruising until she saw them." Z8 stated that she just assumed they were monitoring R1 from falling. Z8 further stated that if R1 doesn't want to do something she will sit down on the floor not drop to the floor, and that it is hard to get her back up. (A)	W9999		