STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. BUILDING _____ B. WING _____	10/30/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN SOUTH NURSING HOME	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 60 During an interview on 10/21/07 at approximately 10:50 AM, R10 stated that on 9/20/07 she had a fall incident. On review of the Nurse's Notes dated 9/20/07, it was documented that R10, "was trying to roll over and adjust herself in the bed" and "found herself on the floor." According to the Nurse's Notes, R10 was sent out to the hospital. R10 was admitted to the hospital with a diagnoses of a closed head injury. Facility staff presented incident reports for review. According to the documentation presented, the fall incident of 9/20/07 was not reported to the state agency until 9/25/07. During an interview, E2 (director of nursing) confirmed that the incident was not reported to the state agency within 24 hours as required 11. R16 is a 88 year old female with diagnoses including deep vein thrombosis, cerebral vascular accident and anemia. Review of R16's nurses' notes dated 8/27/07, showed R16 was noted to have a right swollen knee, an ice pack was applied and the attending physician was notified. R16 was sent to the hospital on 8/28/07 per physician orders where an X-ray diagnosed R16 to have a comminuted right distal femur fracture. An initial investigation was made by the facility on 8/29/07. There was no evidence that the facility submitted the final investigation report to the State Agency to complete the reporting process.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a)	F9999		

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F9999	Continued From page 61 300.1210a) 300.1210b)3) 300.1210b)6) 300.1220b)2) 300.1220b)3) 300.3240a) 300.690 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. 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. b) 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 condiction, 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	F9999		

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F9999	Continued From page 62 made by nursing staff and recorded in the resident's medical record. 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursiing 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. 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. 300.3240 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). These requirements are not met as evidenced by: Based on observations, record reviews and	F9999		

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F9999	Continued From page 63 interviews the facility failed to: A. Failed to investigate, evaluate, update resident assessments and care plans and implement interventions for residents with falls with injuries and falls with risk for injuries. This failure resulted in: -R15 suffering numerous falls that led to multiple injuries including a subdural hematoma and a fracture. The facility failure to provide supervision and interventions to prevent falls resulting in R15's loss of the ability to ambulate. -R35 suffering numerous falls that led to Emergency Room (ER) care. -R17 suffering numerous falls. -R22 suffering numerous falls that led to ER care. -R33 suffering numerous falls that led to a head injury and Hospital care. -R18 suffering numerous falls that led to a head injury that required Hospital care. -R34 suffering numerous falls that led to head injury and ER care. -R10 suffering a closed head injury. B. Investigate potential abuse situations, notify the department of all allegations of potential abuse, notify the appropriate parties, and evaluate injuries of unknown origin as potential abuse. The facility failed to follow their own policy and procedure for abuse reporting and investigation. This is for R22, R32, R16 . C. Failed to investigate and report an injury that occurred during a transfer for R1 to determine if the injury occurred due to improper transfer or due to a problem with resident equipment (siderail). D. Failed to investigate and report an allegation of verbal abuse of R37. Findings include:	F9999		

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F9999	Continued From page 64	F9999		

1. R15 is an 87 year old resident, originally admitted to the facility on 2/9/05 with multiple diagnoses including Senile Dementia and Stroke. Review of R15's Fall risk assessments from 2/15/05 to the most current assessment dated 9/3/07 showed that the resident is at risk for falls. R15's quarterly MDS (minimum data set) dated 5/9/07 showed that the resident is moderately impaired with cognitive skills, independent with bed mobility, transfers,ambulation and locomotion, and requires limited assistance with dressing and toilet use.

Review of R15's nurses' notes dated 6/6/07 (8:25 AM) showed documentation that the resident was sent to the hospital for evaluation due to weakness and lethargy. The nurses' notes dated 6/6/07 (2:15 PM) showed documentation that the resident returned from the hospital. The notes in-part, "Paramedics reported resident sedated in E.R. d/t (due to) combative behavior." "body alarm in place d/t sedation in E.R." The nurse's notes and incident/occurrence report dated 6/6/07 (9:30 PM) showed documentation that the resident was found sitting on a floor mat on her buttocks inside the room. R15 sustained a large bump and bruise above her left eye. R15's POS (physician order sheet) dated 6/6/07 showed an order to send the resident to the hospital if condition worsens.

Review of R15's records showed that the facility was performing neurological checks on the resident for 48 hours after the fall incident with good results. Review of R15's nurses' notes dated 6/8/07 (7-3 shift) showed in-part, "Restorative attempted to stand Pt. (patient). Pt unable to stand per self. Neuro checks performed as ordered. Hand grasps strong and

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F9999	Continued From page 65 equal. Alert and responsive." "Left eye swollen and bruised." The nurses' notes dated 6/10/07 (12:30 PM) showed in-part, "CNA ambulated resident to restroom noted gait unsteady." Nurses' notes dated 6/10/07 (6:00 PM) in-part reads, "Staff walked resident to & from bathroom, gait unsteady." R15's records showed a decline in the resident's physical status several days following the unwitnessed fall on 6/6/07. Review of R15's nurses' notes dated 6/28/07 (2:00 AM) showed documentation that the resident was found sitting on the floor inside the bathroom. This incident was unwitnessed by the staff. Per said nurses' notes, "No apparent injury at this time." Two days after this incident of fall, R15 was sent out to the hospital (6/30/07) due to decline in condition and due to resident leaning on the left side of the body. R15 was sent to the hospital for evaluation and was admitted with diagnosis of acute or chronic left subdural hematoma. A left fronto parietal bur holes and drainage of the subdural hematoma was performed on 7/1/07. R15 was readmitted back to the facility on 7/12/07. An incident/occurrence report dated 8/7/07 (12:00 AM) showed documentation that R15 fell in the common area (TV lounge in front of the nursing station) after attempting to stand up per facility staff. There was no visible injury noted after this incident. Nurses' notes dated 8/9/07 (10:25 PM) showed documentation that the resident was found sitting on the floor in the common area. There was no evidence that an incident report/occurrence report was made after this incident. Review of records showed no evidence that the 8/9/07 fall	F9999		

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F9999	Continued From page 66 was witnessed by the staff. An incident/occurrence report dated 10/17/07 (12:30 AM) showed documentation that R15 was found by the staff on the floor mat after responding to the resident's bed alarm. This incident of fall was not witnessed by the staff. Review of R15's care plan after the fall sustaining injury on 6/6/07 showed no evidence that the facility revised the plan of care to include any monitoring or devices to prevent R15 from having another unwitnessed incident of fall on 6/28/07, even though R15's physical condition showed some decline after the 6/6/07 incident. Further review of R15's care plan showed that the facility did not revise the plan of care for the resident to include any monitoring or devices to prevent R15 from having three more falls after 6/28/07. During interviews held on 10/18/07 at 11:55 AM, Z1 (physician) stated that R15 was possibly having a slow bleed after the fall on 6/6/07 then on 6/28/07 had another unwitnessed fall. Z1 stated that R15 had multiple unwitnessed falls and that she would expect the facility to provide increased monitoring and supervision to ensure that the resident is safe. R15's records showed that prior to the resident's 6/6/07 fall, the resident was mostly independent with her ADL's (activities of daily living). R15's most current significant MDS assessment dated 8/30/07 showed that R15's ADLs have deteriorated. The MDS assessment dated 8/30/07 showed that R15 requires limited assistance with bed mobility, transfers and ambulation in the corridor. R15 is not able to ambulate in the room and would require	F9999		

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F9999	Continued From page 67 extensive assistance with regards to locomotion, dressing and toilet use. Review of R15's nurses' notes dated 9/21/07 showed documentation that multiple X-rays were performed on the resident. Review of R15's X-ray results dated 9/21/07 showed that the resident had pain on the following areas and the results are as follows: - Left knee - no fracture or dislocation - Left ankle - soft tissue swelling without evidence of fracture or dislocation - Left hip - no acute fracture or dislocation - Left femur - no fracture or dislocation - Right hip - there is some slight cortical buckling involving the inferior pubic ramus. The possibility of a fracture here cannot be excluded. Review of R15's nurses' notes dated 9/24/07 showed documentation that the facility received the above X-ray results and the results were relayed to R15's physician with order to send the resident out to the hospital. Review of R15's transfer form from the facility to the hospital dated 9/24/07 showed, "c/o (complaint of) right hip/pelvic pain." Review of R15's records showed documentation that the resident a had history of unwitnessed falls. Further review of R15's records and incident/occurrence reports showed no evidence that the resident had any fall incident/s during the month of September 2007. During interviews held on 10/18/07 at approximately 11:55 AM, Z1 stated that the possible cause of R15's acute fracture of the right inferior pubic ramus was a fall. Z1 stated that the	F9999		

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F9999	Continued From page 68 fall might be unwitnessed or could have been undocumented since R1 has a history of multiple falls. During interviews held on 10/18/07 at approximately 11:00 AM, E2 (Director of nursing) stated that R15's acute fracture of the right inferior pubic ramus was of unknown origin. E2 acknowledged that the facility did not complete an incident/occurrence report and there was no investigation with regards to this injury. E2 also stated that R15's injury that required hospitalization on 9/24/07 was not reported to the Department. 2. R18 is a 86 year old with diagnoses including Mental Status Changes, Head Injury, Status Post Frequent Falls and Right Humerus Fracture. R18's Minimum Data Set (MDS) from 11/30/06 to 09/19/07 shows the resident's cognitive status as requiring cues/supervision, has short term memory problems, and a history of falls with a fracture. During three days of the survey 10/22/07, 10/23/07 and 10/24/07, at various times throughout the day, the resident was observed seated in a wheelchair sitting quietly, wearing a seat belt. Surveyor never witnessed R18 attempting to stand up from the chair. The resident is confused, disoriented to person, place and time, and unable to answer questions appropriately. A review of nurse's notes and incident reports indicate R18 had 7 falls within a two month period of time, from 08/04/07 to 10/20/07 that were preventable. Several of the falls were unwitnessed, and some of the falls resulted in injury.	F9999		

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F9999	Continued From page 69 The incidents are as follows: 08/04/07 at 1:30am, R18 hit left eyebrow on ring on hand sustaining laceration approximately 1 inch with a hematoma; 08/11 at 8:00pm, R18 leaned forward in a chair and bumped center forehead on a night stand; 08/13 at 9:30am, R18 had a fall, and was found on the floor in the bathroom of room; 08/24 at 7:45pm, R18 fell out of the wheelchair in a common area and was found by a family member. The resident was sent to the hospital and returned to the facility on 08/30/07 with a diagnoses including Head Injury; 09/04 at 6:30pm, R18 fell and was found on the floor next to the wheelchair; 09/30 at 3:00am, R18 fell and was found half way on the floor behind the bed and the other half (legs) on the bed; 10/20 at 7:30am, R18 fell from bed onto the floor. There were no re-assessments or interventions implemented after any of the incidents. R18's Fall Risk Assessments of 05/29/07 and 09/07/07 show the resident is at risk for falls. And the fall care plan for the period of 06/05/07 to 10/15/07 has no new, added, or changed interventions. On 10/25/07 at 2:00pm, Z3 (family member) requested to speak with surveyor about R18's fall situation. Z3 stated, "The problem is mostly in the evening where the staff don't watch her (R18). That's when she (R18) falls most of the time." Based on a record review and interview with E3 (CNA/falls coordinator), the facility did not thoroughly investigate the different types of	F9999		

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F9999	Continued From page 70	F9999		

incidents, nor report all the alleged events and all substantiated incidents to the state agency as required, and respond (take corrective measures) to the outcome of the investigations.

E3 was interviewed on 10/24/07 at 11:45am about incidents occurring 08/04/07, 08/11/07, and 08/24/07. E3 stated, "No, we did not file a report to the state. No, I don't have a report."

3. R22 was admitted to the facility on 07/22/07 and was assessed to be at risk for falls with a score of 11. On 08/19/07 the resident was sent out to the hospital for treatment and was noted with a hip dislocation. The hospital record indicates that the reason for the dislocation was a "fall." There is no record nor incident report nor investigation about the incident. The resident returned to the facility on 08/25/07. A new assessment with regards to falls and or risk for falling was not completed. On 09/05/07 resident was found on the floor with redness noted to the eyebrow and fingers. No further follow up or assessment was noted concerning this fall. There is no evidence to support that the physician was notified of this incident. R22's care plan was not updated to reflect the fall. No incident report was completed regarding R22's fall. On 09/18/07 R22 was noted with a bruise to the left hip of "unknown origin." This bruise was not investigated nor was an investigation started to determine how R22 obtained the bruise. No other nursing notes were noted within the medical record about this incident. E3 and E2 were asked for follow-up or an investigation into the bruise, none was provided. The facility did not initiate an investigation for potential abuse related to the bruise of unknown origin. R22 was transferred out of the facility on 10/13/07 to

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F9999	Continued From page 71 another facility. 4. R33 was admitted to the facility on 08/31/07 and promptly fell on 09/05/07, twice that day, and needed treatment in the Emergency Room (ER) for a laceration. R33 was readmitted to the facility on 09/11/07 and fell again on 09/20/07 fell. On 09/22/07 R33 once again fell and sustained a head injury that required treatment in the ER. R33's injury of 09/22/07 was reported to the Department, however the previous incidents were not. The facility failed to investigate the falls and determine the reason for the falls. There is no evidence in the medical record and/or facility files that these injuries were investigated to rule out neglect or abuse. 5. R32 was admitted to the facility on 06/14/07 from the hospital for therapy for a left hip fracture. R32 had a history of Alzheimer's and Hypertension. Review of nurses notes dated 08/23/07 at 3:30 AM notes that R32 fell out of a rocking chair to sitting position, some complaint of pain to right hip. R32's family/physician were notified and an X-ray of the right hip was ordered. Further documentation on 08/23/07 at 8:45 AM denotes R32 was lying in bed complaining of mid-sternal chest pain with radiation to left arm. 911 was called and R32 was transferred to the hospital for evaluation. During review of facility incident reports and review of R32 record, surveyor found a handwritten note written by E12 (RN). The note was regarding concerns called in by R32's family about bruising found around R32's neck and under R32's breasts and allegations that someone may have abused R32.	F9999		

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F9999	Continued From page 72 E12 stated in interview on 10/24/07 she notified E2 (DON) by phone of the allegation by R32's family. E2 stated in interview that she felt the bruising may have been caused by the straps on the ambulance stretcher when R32 was being transferred to the hospital. Review of incident report dated 08/24/07 reporting R32's hospitalization for hip fracture did not include the allegation made by the R32's family of possible abuse by the facility. E1 verified in interview on 10/24/07 she did not report the allegation of abuse to IDPH. Review of R32's incident report lacked a documented investigation/interviews by the facility regarding the bruising or how R32 sustained a hip fracture. E1 stated in interview R32 did not return to the facility after hospitalization. 6. R37 was admitted to the facility on 2/16/07 for status post left rotator cuff repair. Review of R37's initial Minimum Data Set indicates R37 had modified independence in cognition. Review of facility concerns/incident reports revealed an occurrence reported to E3 (LPN/CNA co-coordinator) on 3/8/07 by R37's family. E3 documented R37's family had complained E14 (CNA) had told R37 "I just changed you. You have to sit there," after R37 had requested to use the bathroom. E3 stated she did interview E14 but did not have any documentation regarding the interview of E14. E3 stated her conclusion regarding the incident is that R37 is always crying out to go to the bathroom, and worked out a schedule for R37 to be up and toileted with R37's daughter. E3 stated she did not investigate the concern as an abuse allegation and did not report the incident to IDPH. 7. R35's diagnoses include Depression and	F9999		

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REST HAVEN SOUTH NURSING HOME	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

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F9999	Continued From page 73	F9999		

Anemia. Review of facility incident reports denotes R35 was found on dining room floor on 08/22/07 stating he had a leg cramp and fell. R35 was transferred to hospital and found to have a left hip fracture. Nurses notes of 08/29/07 indicate R35 was readmitted to facility at 5:00 PM, and at 7:10 PM R35 was found again on floor in room. R35 was transferred to hospital emergency room for evaluation. There was no incident report or investigation of R35's fall and no documented information that IDPH was notified of these incidents.

Review of R35 initial fall risk assessment assessed R35 as an 8 low risk for falls. R35's current Minimum Data Set dated 8/17/07 indicates R35 requires 1 person assistance with walking and transfer, due to unsteady gait and uses a wheelchair for mobility.

Review of facility incident report reveals an incident report was not completed until 8/28/07, 6 days after the fall. The incident report does not explore causes of R35's fall on 8/22/07. There was no incident report addressing the fall of 8/29/07.

8. During the initial tour on 10/21/07, surveyor observed R1 lying in bed visiting with family. Surveyor observed a large dark bruise to R1's left lower arm. Surveyor asked R1 how he hurt his arm. R1's son stated "It got caught in the siderail while being transferred from bed." Review of nurses notes dated 10/1/07 indicates "A bruise to left forearm, (R1) stated it happened during routine transfer." Review of facility incident report by E3 documents a bruise was found on R1's left lower arm and the incident was unwitnessed. There was no further investigation of how the

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F9999	Continued From page 74 injury occurred or interview of direct care staff to determine if an improper transfer caused the hematoma. The incident was not reported to IDPH. 9. R34 was a 69 year old resident with diagnoses including hypertension, major depression and history of cerebrovascular accident. Review of the clinical record indicated that the resident has had several falls over the last four months. The facility did not complete incident reports for 2 of the 3 falls. There was no investigation for 3 of the 3 falls. After the the 2nd fall it was determined that the resident had a subarachnoid hematoma. There were no specific interventions attempted to prevent subsequent falls. As a result the resident fell 2 more times and one of the falls resulted in a subarachnoid hematoma. The specifics were as follows: 6/21/07 - The Daily Skilled Nurses Notes stated that the resident was found on the floor with her wheelchair on top of her. "No injuries noted." On 6/22/07 and 6/23/07 the checklist was the only documentation on the resident and there was no mention of the injury. There was no mention of the fall or possible injury. There was no further documentation in the chart until 7/1/07 which stated that the resident had pain in the middle of her chest - the time indicated was 1:00am. There was no assessment of the pain and no mention again for 12 hours when it was documented, "Feels better." 8/31/07 - There was an incident report which stated that a family member was assisting R34 with her walker and she fell. There was no investigation of the incident. The resident was assessed and the physician was notified and a	F9999		

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CT scan was ordered and set up for 9/1/07. When the resident had the scan it was determined that she had a subarachnoid hematoma and she was hospitalized.

9/8/07 - R34 was readmitted to the facility on 9/7/07. It was documented on 9/8/07 that the resident was found on the floor. The note stated that vital signs were assessed and a neuro assessment was started. There was no incident report completed. There was no investigation conducted. There was no further documentation on the status of the resident.

10. R10 is an 82 year old resident who was admitted to the facility on 9/14/07 with diagnoses including diabetes mellitus, congestive heart failure and hypertension. According to the most recent comprehensive resident assessment instrument dated 10/1/07, facility staff identified that R10 has no difficulties with cognitive skills for decision making. Facility staff also identified that R10 has no difficulties with memory or recall. R10 requires extensive assistance with activities of daily living.

During an interview on 10/21/07 at approximately 10:50 AM, R10 stated that on 09/20/07 she had a fall incident. On review of the Nurse's Notes dated 09/20/07, it was documented that R10, "was trying to roll over and adjust herself in the bed" and "found herself on the floor." According to the Nurse's Notes, R10 was sent out to the hospital. R10 was admitted to the hospital with a diagnoses of a closed head injury.

Facility staff presented incident reports for review. According to the documentation presented, the fall incident of 09/20/07 was not

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F9999	Continued From page 76 reported to the state agency until 09/25/07. During an interview, E2 (director of nursing) confirmed that the incident was not reported to the state agency within 24 hours as required 11. R16 is an 88 year old female with diagnoses that include Deep vein thrombosis, cerebral vascular accident and anemia. Review of R16's nurses' notes dated 08/27/07, showed R16 was noted to have a right swollen knee, an ice pack was applied and the attending physician was notified. R16 was sent to the hospital on 08/28/07 per physician orders where an X-ray diagnosed R16 to have a comminuted right distal femur fracture. An initial investigation was made by the facility on 08/29/07. There was no evidence that the facility submitted the final investigation report to the State Agency to complete the reporting process. During an interview held on 10/18/07 at approximately 1:00 PM, E2 acknowledged that the facility did not submit the final report as to the outcome of the facility's incident investigation to the State agency with regards to R16's femur fracture. 12. R17's diagnoses includes Cerebral Vascular Accident, and Osteoarthritis. Review of current MDS assessed R17 with moderate cognitive impairment, requires assistance in activities of daily living, and has a history of recent falls. Review of nurses notes and incident reports documents the following falls: 8/21/07-found on floor in room -no injury 8/30/07-found on floor in room-no injury 9/25/07-found on floor in room-no injury 9/26/07-found on floor in room-no injury	F9999		

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F9999	Continued From page 77 10/19/07-found on floor in room-no injury Review of the nurse notes indicate R17's falls were due to R17 trying to transfer herself to bed or to the toilet. A bed/chair alarm was used as an intervention, but documentation in the nurses notes and incident reports were inconsistent in reporting if the bed/chair alarm was being utilized. There was no follow up or monitoring of R17 after each fall. Review of current care plan indicates an intervention on 10/19/07 for R17 to be assisted to bed by 7:00 PM because of falling between 7-7:10 PM. The intervention was not put into place until after R17 had 4 unwitnessed falls. 13. Facility Policies and Procedures Review of the facility policy and procedure regarding unusual Occurrence report/unusual occurrence investigation showed, in part, the following: "Policy: Licensed personnel are responsible for the initiation and completion of the unusual occurrence report/unusual occurrence investigation." "Purpose: To complete an unusual occurrence report/unusual occurrence investigation: Unexplained fractures. Where there is an injury or the potential to result in an injury." "Procedures: 5. Notify the Public Health Department and other agencies according to regulations, 6. Complete the occurrence report legibly and completely and send to nursing office." "Unexplained Fractures: 1. "Unexplained	F9999		

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F9999	Continued From page 78 fractures" are investigated soon after discovery." Review of the facility policy and procedure regarding abuse reporting/response showed in-part the following: "Policy: All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of an unknown source and misappropriation of resident property." "Procedures: 2. Any alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported to the administrator. 3. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported and substantiated through a thorough investigation, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: a. State Licensing and Certification Agency (Department of Public Health). 4. All personnel (are required), residents, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. 7. Upon receiving reports of physical or sexual abuse, the charge nurse shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. 8. The charge nurse must complete an unusual occurrence report and obtain a written, signed, and dated statement from the person reporting the incident." Review of the facility policy and procedure regarding abuse investigation showed in-part the following:	F9999		

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F9999	Continued From page 79 "Procedures: 1. When an incident or suspected incident of resident abuse, neglect, misappropriation of resident property, or injury of an unknown source is reported, the person in charge will immediately begin the investigation, and will have the option of appointing a different staff member or him/herself to investigate the incident after the designee is notified. 2. The designee will provide to the person in charge of the investigation a copy of the Unusual Occurrence Report and any supporting documents relative to the incident. 3. The investigation shall consist of any or all of the following as appropriate:a. A review of the completed Unusual Occurrence Report; b. An interview with the person(s) reporting the incident; c. Interviews with any witnesses to the incident; d. An interview with the resident; e. An interview with the resident's attending physician and review of the resident's medical record; f. An interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident; g. Interviews with the resident's roommate, family members, and visitors; h. Interviews with other residents to which the accused employee provides care or services; i. Review of the personnel record of staff involved for a verification of certification/licensure of CNA and licensed staff involved; assure that criminal background checks are in place; each staff members orientation to the facility is complete and executed (including information regarding resident rights and abuse policy); verification if the employee has attended in-service on resident rights; and j. A review of all circumstances surrounding the incident. 4. Witness reports shall be made in writing. 5. While the investigation is being conducted, accused	F9999		