STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 10/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ROLLING MEADOWS	**4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008**

(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 000	INITIAL COMMENTS Complaint Investigations: 0994228 - IL43803 - No deficiencies 0994442 - IL44031 F223 & F225 A partial extended survey was conducted.	F 000		
F 223 SS=J	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 2 of 10 sampled residents (R1& R2) are free of physical abuse by staff. This failure resulted in an Immediate Jeopardy. E1 (Administrator) was notified of the Immediate Jeopardy on 10/21/09 at 4:15p.m. The Immediate Jeopardy was determined to have begun on 09/05/09 at approximately 8p.m. While the Immediate Jeopardy was abated on 09/09/09 when E4 was suspended and subsequently terminated the facility remains out of compliance at a severity Level II. Findings Include: 1. During entrance conference on 10/21/09 at 9:10a.m. E2 (Director of Nurses-DON) was asked if facility had any recent investigations of alleged abuse. During interview E2 stated there	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F 223	Continued From page 1 was an investigation of alleged abuse initiated on 09/09/09 involving R2. E2 stated E4 (Nurse Aide-CNA) was suspended pending investigation and subsequently terminated because allegation of abuse was substantiated. E2 also stated E6 (CNA) was terminated for not reporting alleged abuse of R2 in addition to previous issues. E2 also stated that on 09/09/09 E5 reported witnessing E4 slap R1 on 09/05/09. R2 is 64 years old and diagnoses includes right craniotomy due to right lateral meningioma, ventriculoperitoneal shunt due to hydrocephalus, history of agitation, irritability and combativeness. Nurses note dated 09/09/09 at 6:45a.m. states at 12:30a.m. this writer was informed by CNA that R2's left third finger looks purplish in color Assessment to the finger done and found the finger is swollen and purplish in color. R2 denies pain, but unable to bend and said 'this is my bad hand and these fingers were like this even before this happened.' R2 was asked what happened and stated 'two girls right out the boat from Vietnam jumped on me.' Cold compresses were applied and physician ordered X-ray of finger to rule out fracture. Nurses note dated 09/09/09 at 3:30p.m. stated R2's third finger greenish/yellow in color with slight swelling. Xray negative for fracture. R2 states two women CNA's told her she looked strong but they were stronger, jumped her and took it out on her. On 09/09/09 E2 initiated an investigation of incident involving R2. On 09/09/09 at 12p.m. E2 obtained a statement by R2. Statement reads; This was done to me by two female CNA's, one of them was E6. They were twisting and wiggling	F 223		

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F 223	Continued From page 2 my finger. They said to me "you think you are strong but we are stronger." When asked if the CNA's were trying to help her she said "no they were trying to harass me." On 09/09/09 at 2p.m. E2 obtained E6's statement which reads; On Sunday (09/06/09) she helped E4 around 3:30p.m. to 4p.m. R2 was fighting. E4 wrapped R2's right hand with a washcloth and she asked me to hold her R2's right hand. I did not. E4 was getting upset. E4 held R2's right hand and was pointing a finger at her saying "don't fight me." E4 was getting hot tempered because before she wrapped R2's hand, she got a scratch on the forehead. On 09/10/09 at 10:00a.m. E2 obtained E4's statement which reads; R2 doesn't like the ladies. When she sees me she says "get out from here.' We just talk to her politely. I worked with her last Sunday (09/06/09). Me and E6 got her up. She was still in bed when I came. We changed her, she kicked us and started fighting. This was about 4:30p.m. We were using the standing lift. She scratched me on the forehead. I told E6. R2 moved her hand and hit the lift. She tried to beat me with her good hand. I told E6 that she hit her hand on the lift I held her hand I told her "please be quiet". She talk using words F____B____. I held her right hand. I did not do anything else. I wrapped her right hand with the bed sheet up the arm above her wrist. It was not the right thing to do. R2's current care plan dated 06/15/09 states R2 had alteration in activities of daily living (ADL's) related to limited mobility and cognitive impairment. Needs total assist for most ADL's and at times is resistive to care from staff. Care	F 223		

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F 223	Continued From page 3 plan approaches to these identified problems are; approach R2 in a gentle manner and explain what you are going to do. Re-approach later and/or differently if resistant. Results of final investigation report dated 09/11/09 by E1 (Administrator) states; On 09/09/09 R2 reported to staff that several days earlier her hand had been pushed back by staff members while providing care. At the time of the report R2 was unable to determine the date that the incident occurred. Staff member who R2 identified was suspended (E6). Upon investigation it was learned that another CNA (E4) had tied down R2 wrists during care. Based upon witness statements and E4's own statement it was determined that the allegation of abuse is founded and E4 was terminated from employment. 2. During interview on 10/21/09 at 8:50a.m. E3 (Director of Care Delivery) was asked if facility had investigated any recent allegations of abuse of a resident. E3 stated that a CNA did approach her and was not sure if something was reportable. E3 stated this CNA (name not given) stated she observed another CNA holding R1's hand and observed what she considered a bit of a slap. E3 did state there was a delay in the reporting this concern. At approximately 9a.m. on 10/21/09 E2 arrived in the facility and interviews continued with E2. E2 stated that on 09/09/09 she began the investigation regarding R2 and on the same day E5 (CNA) reported that she observed E4 slap R1's hand on 09/05/09 at approximately 8p.m. On 09/09/09 at 5p.m. E2 obtained E5's statement which reads; I went to go ask E4 for her help at	F 223		

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F 223	Continued From page 4 8p.m. I went to room 184. The door was open and curtain was drawn. I walked to E4. She was trying to take off R1's shirt. R1 pinched E4, I think on her left hand, and then E4 slapped her hand like you would slap a kids hand if they do something wrong. I don't know for sure, it as probably the right hand. When asked if E4 slapped R1's hand, E5 responded "enough for us to notice." I don't remember how R1 reacted. I told E4 you can't slap her. E4 showed me her hand and said "look she pinched me." Then I left the room. On 09/10/09 at 10a.m. E2 obtained E4's statement which reads; When I was putting R1 to bed she pinched my left breast. She was on her chair in her room. Me and E5 were trying to sit her up, it was to early to put her to bed. When she pinched me, my hand went up and by mistake I hit her on the arm (not on the hand). E5 told me "you cannot do this." I said it was by mistake. After she pinched me I held her hand with a little force. R1's current care plan dated 09/01/09 states R1 can be verbally and physically aggressive to caregivers by biting and scratching. Interventions include approach calmly, maintain distance until resident is calm and if resident is resistive, return at a later time. Results of investigation dated 09/11/09 by E1 (Administrator) states; On 09/05/09 A staff member reported witnessing another staff member slap R1 on the hand. R1 is unable to communicate and therefore the facility was unable to obtain a statement from her The staff member was suspended, family and physician were notified. A full body assessment was also	F 223		

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F 223	Continued From page 5 conducted with no findings. Upon investigation and subsequent interviews the facility was unable to substantiate the allegation. This allegation was not reported on 09/05/09 as stated above. As previously stated E5 reported this observation on 09/09/09. Four days later. During interview on 10/21/09 E1 was asked why alleged abuse of R1 was unfounded even though it was witnessed by a staff person. E1 stated E4 had no prior concerns with residents, no redness was found on R1 and no other resident had any issues or concerns with E4. Surveyor did state that the investigation did not begin until four days after alleged abuse because it was not reported for four days. The Facility took the following steps to remove the Immediate Jeopardy: On 09/09/09, after an injury of unknown origin was identified, R2 received an assessment by the nurse supervisor and there were no other physical findings. There were no changes noted in the resident's mood, behavior or affect. The physician and family were notified. The left third finger was discolored and swollen. X-ray was ordered and completed on 09/09/09 with no findings. On 09/09/09 CNA (E5) reported a potential allegation of staff to resident abuse related to R1. An assessment was completed on R1. There were no physical findings that substantiated the allegation of abuse. There were no changes noted in the residents mood, behavior or affect. Physician and family were notified No new orders were given. The administrator notified the	F 223		

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F 223	Continued From page 6 police of the allegation of abuse on 09/09/09. On 09/09/09, the Administrative Director of Nursing re-inserviced CNA (E5) regarding the immediate reporting of allegation of abuse, neglect and misappropriation of property. The employee received previous education on abuse reporting. When allegation were reported, employees (E4 & E6) were suspended and investigation was initiated. Employees were subsequently terminated. Assessments were completed by nurse supervisor on non-interviewable resident in rooms 203 through 221. There were no physical findings that substantiated any allegation of abuse. Assessments were completed by nurse supervisor on non-interviewable residents in rooms 179 through 186. There were no physical findings that substantiated any allegation of abuse. In addition, interviews were conducted on interviewable residents to identify concerns related to staff treatment of residents. None of the interviewable resident's verbalized concerns related to the care they receive or the care provided to other residents. The Administrator and Administrative Director of Nursing/Designee have completed re-inservice education on Abuse-Neglect-Misappropriation of Resident Property with the center staff on 10/21/09 through 10/23/09.	F 223		

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F 223	Continued From page 7 The Administrator and Administrative Director of Nursing/Designee have completed with staff, in-service education on delivery of care for residents who are sensitive to care and/or have demonstrated combative behaviors to other residents and/or staff 10/22/09 through 10/25/09. New Employees are in-serviced on Abuse-Neglect-Misappropriation of Resident Property during orientation prior to patient contact by Human Resources (HR) or designee Annual in-services on Abuse-Neglect-Misappropriation of Resident Property is completed by center staff. Validation that center staff has completed the Abuse-Neglect-Misappropriation of Resident Property in-service is done by HR who submits a report to the QAA Committee for follow-up to ensure the education is completed. Care Plans that identify interventions for patients that resist care will be placed in the CNA data book for review and use. Monitoring to ensure direct care delivery is consistent with plan of care to residents identified as resistive to care, shall be completed through morning QAA meetings. Weekly QAA audits will be completed by Administrative Director of Nursing/Designee of direct care delivery for 30 days to monitor direct care delivery provided to patients that are resistive to care and to validate that care plan is being followed. The weekly QAA audits will be submitted to the QAA Committee for review and	F 223		

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F 223	Continued From page 8 recommendations to sustain compliance.	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure that two Certified Nurse Aides (E5 & E6) report observations of alleged abuse at the time of observation for 2 of 9 sampled residents (R1& R2). The failure of E5 to report observations on 09/05/09 regarding R1, allowed E4 to continue working and mistreat R2 on 09/06/09. These failures resulted in an Immediate Jeopardy. E1 (Administrator) was notified of the Immediate Jeopardy on 10/21/09 at 4:15p.m. The Immediate Jeopardy was determined to have begun on 09/05/09 at approximately 8p.m. when E5 witnessed an alleged abuse of R1 and did not report observations until 09/09/09. E6 also failed to report witnessing an alleged abuse of R2 on 09/06/09. While the Immediate Jeopardy was abated on 09/09/09 when E4 was suspended and subsequently terminated, the facility remains out of compliance at a severity Level II. Findings Include: 1. During entrance conference on 10/21/09 at 9:10a.m. E2 (Director of Nurses-DON) was asked if facility had any recent investigations of alleged abuse. During interview E2 stated there was an investigation of alleged abuse initiated on 09/09/09 involving R2. E2 stated E4 (Nurse Aide-CNA) was suspended pending investigation and subsequently terminated because allegation of abuse was substantiated. E2 also stated E6	F 225		

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F 225	Continued From page 10 (CNA) was terminated for not reporting alleged abuse of R2 in addition to previous issues. E2 also stated that on 09/09/09 E5 reported witnessing E4 slap R1 on 09/05/09. R2 is 64 years old and diagnoses includes right craniotomy due to right lateral meningioma, ventriculoperitoneal shunt due to hydrocephalus, history of agitation, irritability and combativeness. Nurses note dated 09/09/09 at 6:45a.m. states at 12:30a.m. this writer was informed by CNA that R2's left third finger looks purplish in color Assessment to the finger done and found the finger is swollen and purplish in color. R2 denies pain, but unable to bend and said 'this is my bad hand and these fingers were like this even before this happened.' R2 was asked what happened and stated 'two girls right out the boat from Vietnam jumped on me.' Cold compresses were applied and physician ordered X-ray of finger to rule out fracture. Nurses note dated 09/09/09 at 3:30p.m. stated R2's third finger greenish/yellow in color with slight swelling. Xray negative for fracture. R2 states two women CNA's told her she looked strong but they were stronger, jumped her and took it out on her. On 09/09/09 E2 initiated an investigation of incident involving R2. On 09/09/09 at 12p.m. E2 obtained a statement by R2. Statement reads; This was done to me by two female CNA's, one of them was E6. They were twisting and wiggling my finger. They said to me "you think you are strong but we are stronger When asked if the CNA's were trying to help her she said "no they were trying to harass me."	F 225		

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F 225	Continued From page 11 On 09/09/09 at 2p.m. E2 obtained E6's statement which reads; On Sunday (09/06/09) she helped E4 around 3:30p.m. to 4p.m. R2 was fighting. E4 wrapped R2's right hand with a washcloth and she asked me to hold her R2's right hand. I did not. E4 was getting upset. E4 held R2's right hand and was pointing a finger at her saying "don't fight me." E4 was getting hot tempered because before she wrapped R2's hand, she got a scratch on the forehead. On 09/10/09 at 10:00a.m. E2 obtained E4's statement which reads; R2 doesn't like the ladies. When she sees me she says "get out from here.' We just talk to her politely. I worked with her last Sunday (09/06/09). Me and E6 got her up. She was still in bed when I came. We changed her, she kicked us and started fighting. This was about 4:30p.m. We were using the standing lift. She scratched me on the forehead. I told E6. R2 moved her hand and hit the lift. She tried to beat me with her good hand. I told E6 that she hit her hand on the lift I held her hand I told her "please be quiet". She talk using words F____B____. I held her right hand. I did not do anything else. I wrapped her right hand with the bed sheet up the arm above her wrist. It was not the right thing to do. R2's current care plan dated 06/15/09 states; R2 had alteration in activities of daily living (ADL's) related to limited mobility and cognitive impairment. Needs total assist for most ADL's and at times is resistive to care from staff. Care plan approaches to these identified problems are; approach R2 in a gentle manner and explain what you are going to do. Re-approach later and/or differently if resistant. Results of final investigation report dated	F 225		

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F 225	Continued From page 12 09/11/09 by E1 (Administrator) states; On 09/09/09 R2 reported to staff that several days earlier her hand had been pushed back by staff members while providing care. At the time of the report R2 was unable to determine the date that the incident occurred. Staff member who R2 identified was suspended (E6). Upon investigation it was learned that another CNA (E4) had tied down R2 wrists during care. Based upon witness statements and E4's own statement it was determined that the allegation of abuse is founded and E4 was terminated from employment. Investigation did not contain any statement by E6 as to why observations of alleged abuse/mistreatment were not reported at time of observation. 2. During interview on 10/21/09 at 8:50a.m. E3 (Director of Care Delivery) was asked if facility had investigated any recent allegation of abuse of a resident. E3 stated that a CNA did approach her on 09/09/09 and was not sure if something was reportable. E3 stated this CNA (name not given) stated she observed another CNA holding R1's hand and observed what she considered a bit of a slap. E3 did state there was a delay in the reporting this concern. At approximately 9a.m. on 10/21/09, E2 arrived in the facility and interviews continued with E2. E2 stated that on 09/09/09 she began the investigation regarding R2 and on the same day E5 (CNA) reported that she observed E4 slap R1's hand on 09/05/09 at approximately 8p.m. On 09/09/09 at 5p.m. E2 obtained E5's statement which reads; I went to go ask E4 for her help at 8p.m. I went to room 184. The door was open	F 225		

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	145350	A. BUILDING _____ B. WING _____	C 10/29/2009

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F 225	Continued From page 13	F 225		

and curtain was drawn. I walked to E4. She was trying to take off R1's shirt. R1 pinched E4, I think on her left hand, and then E4 slapped her hand like you would slap a kids hand if they do something wrong. I don't know for sure, it as probably the right hand. When asked if E4 slapped R1's hand, E5 responded "enough for us to notice." I don't remember how R1 reacted. I told E4 you can't slap her. E4 showed me her hand and said "look she pinched me." Then I left the room.

On 09/10/09 at 10a.m. E2 obtained E4's statement which reads; When I was putting R1 to bed she pinched my left breast. She was on her chair in her room. Me and E5 were trying to sit her up, it was to early to put her to bed. When she pinched me my hand went up and by mistake I hit her on the arm (not on the hand). E5 told me "you cannot do this." I said it was by mistake. After she pinched me I held her hand with a little force.

R1's current care plan dated 09/01/09 states R1 can be verbally and physically aggressive to caregivers by biting and scratching. Interventions include approach calmly, maintain distance until resident is calm and if resident is resistive, return at a later time.

Results of final investigation report dated 09/11/09 by E1 (Administrator) states; On 09/05/09 A staff member reported witnessing another staff member slap R1 on the hand. R1 is unable to communicate and therefore the facility was unable to obtain a statement from her The staff member was suspended, family and physician were notified. A full body assessment was also conducted with no findings. Upon

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F 225	Continued From page 14 investigation and subsequent interviews the facility was unable to substantiate the allegation. This allegation was not reported on 09/05/09 as stated above. As previously stated E5 reported this observation on 09/09/09, four days later. During interview on 10/21/09 E1 was asked why alleged abuse of R1 was unfounded even though it was witnessed by a staff person. E1 stated E4 had no prior concerns with residents, no redness was found on R1 and no other resident had any issues or concerns with E4. Surveyor did state that the investigation did not begin until four days after alleged abuse. During interview on 10/21/09 E1 and E2 were asked if E5 had made any statement as to why she waited four days to report the allegation. E1 stated E5 said she did not know who to report to, but this statement was not written as part investigation. The Facility took the following steps to remove the Immediate Jeopardy: On 09/09/09, after an injury of unknown origin was identified, R2 received an assessment by the nurse supervisor and there were no other physical findings. Tere were no changes noted in the resident's mood, behavior or affect. The physician and family were notified. The left third finger was discolored and swollen. X-ray was ordered and completed on 09/09/09 with no findings. On 09/09/09 CNA (E5) reported a potential allegation of staff to resident abuse related to R1. An assessment was completed on R1. There	F 225		

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F 225	Continued From page 15 were no physical findings that substantiated the allegation of abuse. There were no changes noted in the residents mood, behavior or affect. Physician and family were notified No new orders were given. The administrator notified the police of the allegation of abuse on 09/09/09. On 09/09/09, the Administrative Director of Nursing re disservice CNA (E5) regarding the immediate reporting of allegation of abuse, neglect and misappropriation of property. The employee received previous education on abuse reporting. When allegation were reported, employees (E4 & E6) were suspended and investigation was initiated. Employees were subsequently terminated. Assessments were completed by nurse supervisor on non-interviewable resident in rooms 203 through 221. There were no physical findings that substantiated any allegations of abuse. Assessment were completed by nurse supervisor on non-interviewable residents in rooms 179 through 186. There were no physical findings that substantiated any allegations of abuse. In addition, interviews were conducted on interviewable residents to identify concerns related to staff treatment of residents None of the interviewable resident's verbalized concerns related to the care they receive or the care provided to other residents. The Administrator and Administrative Director of Nursing/Designee have completed re-inservice	F 225		

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F 225	Continued From page 16 education on Abuse-Neglect-Misappropriation of Resident Property with the center staff on 10/21/09 through 10/23/09. The Administrator and Administrative Director of Nursing/Designee have completed with staff, in-service education on delivery of care for residents who are sensitive to care and/or have demonstrated combative behaviors to other residents and/or staff 10/22/09 through 10/25/09. New Employees are in-serviced on Abuse-Neglect-Misappropriation of Resident Property during orientation prior to patient contact by Human Resources (HR) or designee. Annual in-services on Abuse-Neglect-Misappropriation of Resident Property is completed by center staff. Validation that center staff has completed the Abuse-Neglect-Misappropriation of Resident Property in-service is done by HR who submits a report to the QAA Committee for follow-up to ensure the educations is completed. Care Plans that identify interventions for patients that resist care will be placed in the CNA data book for review and use. Monitoring to ensure direct care delivery is consistent with plan of care to patients identified as resistive to care, shall be completed through morning QAA meetings. Weekly QAA audits will be completed by Administrative Director of Nursing/Designee of direct care delivery for 30 days to monitor direct care delivery provided to patients that are resistive to care and to validate that care plan is	F 225		

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F 225	Continued From page 17 being followed. The weekly QAA audits will be submitted to the QAA Committee for review and recommendations to sustain compliance.	F 225		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a) 300.3240b) 300.3240e) 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. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. These Regulations were not met as evidenced by: Based on record review and interviews the facility	F9999		

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F9999	Continued From page 18 failed to ensure that 2 of 10 sampled residents (R1& R2) are free of physical abuse by staff. Findings Include: 1. During entrance conference on 10/21/09 at 9:10a.m. E2 (Director of Nurses-DON) was asked if facility had any recent investigations of alleged abuse. During interview E2 stated there was an investigation of alleged abuse initiated on 09/09/09 involving R2. E2 stated E4 (Nurse Aide-CNA) was suspended pending investigation and subsequently terminated because allegation of abuse was substantiated. E2 also stated E6 (CNA) was terminated for not reporting alleged abuse of R2 in addition to previous issues. E2 also stated that on 09/09/09 E5 reported witnessing E4 slap R1 on 09/05/09. R2 is 64 years old and diagnoses include right craniotomy due to right lateral meningioma, ventriculoperitoneal shunt due to hydrocephalus, history of agitation, irritability and combativeness. Nurses note dated 09/09/09 at 6:45a.m. states at 12:30a.m. this writer was informed by CNA that R2's left third finger looks purplish in color Assessment to the finger done and found the finger is swollen and purplish in color. R2 denies pain, but unable to bend and said 'this is my bad hand and these fingers were like this even before this happened.' R2 was asked what happened and stated 'two girls right out the boat from Vietnam jumped on me.' Cold compresses were applied and physician ordered X-ray of finger to rule out fracture. Nurses note dated 09/09/09 at 3:30p.m. states R2's third finger greenish/yellow in color with	F9999		

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F9999	Continued From page 19 slight swelling. Xray negative for fracture. R2 states two women CNA's told her she looked strong but they were stronger, jumped her and took it out on her. On 09/09/09 E2 initiated an investigation of incident involving R2. On 09/09/09 at 12:00p.m. E2 obtained a statement by R2. Statement reads: This was done to me by two female CNA's, one of them was E6. They were twisting and wiggling my finger. They said to me "you think you are strong but we are stronger." When asked if the CNA's were trying to help her she said "no they were trying to harass me." On 09/09/09 at 2:00p.m. E2 obtained E6's statement which reads: On Sunday (09/06/09) she helped E4 around 3:30p.m. to 4:00p.m. R2 was fighting. E4 wrapped R2's right hand with a washcloth and she asked me to hold her R2's right hand. I did not. E4 was getting upset. E4 held R2's right hand and was pointing a finger at her saying "don't fight me." E4 was getting hot tempered because before she wrapped R2's hand, she got a scratch on the forehead. On 09/10/09 at 10:00a.m. E2 obtained E4's statement which reads: R2 doesn't like the ladies. When she sees me she says "get out from here." We just talk to her politely. I worked with her last Sunday (09/06/09). Me and E6 got her up. She was still in bed when I came. We changed her, she kicked us and started fighting. This was about 4:30p.m. We were using the standing lift. She scratched me on the forehead. I told E6. R2 moved her hand and hit the lift. She tried to beat me with her good hand. I told E6 that she hit her hand on the lift I held her hand I told her "please be quiet". She talk using words F____B____. I	F9999		

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F9999	Continued From page 20	F9999		

held her right hand. I did not do anything else. I wrapped her right hand with the bed sheet up the arm above her wrist. It was not the right thing to do.

R2's current care plan dated 06/15/09 states R2 had alteration in activities of daily living (ADL's) related to limited mobility and cognitive impairment. Needs total assist for most ADL's and at times is resistive to care from staff. Care plan approaches to these identified problems are: approach R2 in a gentle manner and explain what you are going to do. Re-approach later and/or differently if resistant.

Results of final investigation report dated 09/11/09 by E1 (Administrator) states: On 09/09/09 R2 reported to staff that several days earlier her hand had been pushed back by staff members while providing care. At the time of the report R2 was unable to determine the date that the incident occurred. Staff member who R2 identified was suspended (E6). Upon investigation it was learned that another CNA (E4) had tied down R2 wrists during care. Based upon witness statements and E4's own statement it was determined that the allegation of abuse is founded and E4 was terminated from employment.

2. During interview on 10/21/09 at 8:50a.m. E3 (Director of Care Delivery) was asked if facility had investigated any recent allegations of abuse of a resident. E3 stated that a CNA did approach her and was not sure if something was reportable. E3 stated this CNA (name not given) stated she observed another CNA holding R1's hand and observed what she considered a bit of a slap. E3 did state there was a delay in the

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F9999	Continued From page 21	F9999		

reporting this concern.
At approximately 9:00a.m. on 10/21/09 E2 arrived in the facility and interviews continued with E2. E2 stated that on 09/09/09 she began the investigation regarding R2 and on the same day E6 (CNA) reported that she observed E4 slap R1's hand on 09/05/09 at approximately 8:00p.m.

On 09/09/09 at 5:00p.m. E2 obtained E5's statement which reads: I went to go ask E4 for her help at 8:00p.m. I went to room 184. The door was open and curtain was drawn. I walked to E4. She was trying to take off R1's shirt. R1 pinched E4, I think on her left hand, and then E4 slapped her hand like you would slap a kids hand if they do something wrong. I don't know for sure, it as probably the right hand. When asked if E4 slapped R1's hand, E4 responded "enough for us to notice." I don't remember how R1 reacted. I told E4 you can't slap her. E4 showed me her hand and said "look she pinched me." Then I left the room.

On 09/10/09 at 10:00a.m. E2 obtained E4's statement which reads; When I was putting R1 to bed she pinched my left breast. She was on her chair in her room. Me and E5 were trying to sit her up, it was to early to put her to bed. When she pinched me, my hand went up and by mistake I hit her on the arm (not on the hand). E5 told me "you cannot do this." I said it was by mistake. After she pinched me I held her hand with a little force.

R1's current care plan dated 09/01/09 states R1 can be verbally and physically aggressive to caregivers by biting and scratching. Interventions include approach calmly, maintain distance until

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F9999	Continued From page 22 resident is calm and if resident is resistive, return at a later time. Results of investigation dated 09/11/09 by E1 (Administrator) states: On 09/05/09 A staff member reported witnessing another staff member slap R1 on the hand. R1 is unable to communicate and therefore the facility was unable to obtain a statement from her The staff member was suspended, family and physician were notified. A full body assessment was also conducted with no findings. Upon investigation and subsequent interviews the facility was unable to substantiate the allegation. This allegation was not reported on 09/05/09 as stated above. As previously stated E5 reported this observation on 09/09/09. Four days later. During interview on 10/21/09 E1 was asked why alleged abuse of R1 was unfounded even though it was witnessed by a staff person. E1 stated E4 had no prior concerns with residents, no redness was found on R1 and no other resident had any issues or concerns with E4. Surveyor did state that the investigation did not begin until four days after alleged abuse because it was not reported for four days. (A)	F9999		