STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145834	A. BUILDING _____ B. WING _____	C 10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBUS PARK N & REHAB CENTER	**901 SOUTH AUSTIN CHICAGO, IL 60644**

(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 1181317/IL52757 - no deficiencies 1181221/IL52656 - no deficiencies 1181925/IL53449 - no deficiencies 1181637/IL53097 - F157, F223, F226, F309, F508 1182013/IL53540 - F309 1182269/IL53846 - no deficiencies 1182119/IL53673 - no deficiencies 1182084/IL53620 - no deficiencies	F 000		
F 157 SS=D	Incident investigation 3/18/11 / IL53308 - F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		10/31/11

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

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the attending physician or medical director in a timely manner for 2 of 3 residents R8, R9, R8 who refused a prescribed treatment after being involved in a fall incident., and R9 complained of pain to the left arm, and assessed to have bruising to the left arm and leg, subsequently assess to have fracture. Findings include: 1). According to the facility's incident report dated 3/14/11 11:30am the charge nurse was called to the first floor bathroom, R8 was noted on the floor. The report indicates that the nurse asked what happened, and R8 indicates that he bent over to get his wallet. R8 was assessed to be alert, with injuries noted. The incident report denotes that R8 was not taken to the hospital after the fall incident. According to the facility's investigaqtion dated	F 157		

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F 157	Continued From page 2 3/18/11 3:00pm denotes R8 to be alert and oriented able to make needs know. The report indicates that R8 complained of right hip pain after being transferred to bed. The report indicates the charge nurse assessed R8 and notified the physician, and order were given for pain medication and x-ray to the hip. The report indicates suspicious fracture of the neck of the femur. Again the physician was made aware of the results and R8 was sent to the hospital for evaluation. The local hospital notified the facility that R8 was admitted with hip fracture. According to R8's nurses notes dated 3/14/11 11:30am charge nurse called to first floor bathroom and asked R8 what happened and R8 said that he ben over to get his wallet, and fell. The note indicates no complaints of pain when placing R8 into wheel chair. The note indicates that outpatient radiology called to perform x-ray to the right leg. Nurse notes dated 3/14/11 indicates that physician and power of attorney made of aware of the fall, and the physician orders. Nurse note 3/14/11 10:00pm outpatient radiology at the facility to obtain the x-ray and R8 is noted as refusing to allow the x-ray to be done because it was too late. The note indicates that the physician was paged with no return call. Nurse note 3/14/11 at 11:00pm denotes that R8 physician was paged (2) more times with no return call. Nurse note 3/15/11 7:00am indicates R8 had no complaints of pain throughout the night, and endorsement to call physician and notify of R8's refusal of x-ray at 10:00pm. 3/15/11 10:00am nurse note indicates that R8 physician was notified of the refusal of care, and gave orders to continue to monitor and assess R8 for pain of discomfort.	F 157		

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F 157	Continued From page 3 On 8/5/11 at 10:00am via telephone E2 (director of nursing), said that when the attending physician is not reached the nursing staff are expected to notify the medical director, E2 said if the attending physician does not return call in over an hour then the medical director should be notified. E2 said that the facility don't have a policy guideline, but said it is the facility's practice to notify the medical director when the attending physician was not returning calls. E2 was unable to verbalize why after several unanswered pages from the attending physician, the nursing staff didn't notify the medical director. According to the facility's change in condition or status policy, the facility shall promptly notify the resident, attending physician of changes in the residents condition. The procedure includes the nurse shall notify the attending physician when there is a need alter the residents treatment, and if a resident refuses a treatment. 2). Nursing notes dated 5/16/11 2:00pm indicates R9 lying in bed comfortable. The note indicates that R9 complained to the nurse that a certified nurse aide hurt my arm. The note indicates upon assessment no redness, bruising, or swelling noted. The nurse note indicated when arm was touched R9 complained of pain. The note indicates that the physician was paged. Nurse notes 5/16/11 3:30pm denotes multiple bruise on the left arm, and leg. R9 again complained of pain at the left arm the note indicates that R9 was assessed as 8 of 10 on the pain scale (0 no pain -10 highest pain). The note indicates pain medication given at this time. The	F 157		

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F 157	Continued From page 4 note indicates that R9 pain was reduced to 3 of 10 within 1 hour. Again the note indicates that the physician was paged. Nursing note 5/17/11 4:00am indicates R9 ambulating in the hallway, nurse note indicates bruising, redness and swelling to the left elbow and forearm. R9's skin noted warm to touch with limited mobility to the arm. Again R9's physician was paged with nurse noting orders received for left arm x-ray. The note indicates that outpatient radiology telephoned. Nurse note 5/17/11 at 7:00am indicates that charge nurse made aware of R9's status of left arm. The indicates that R9 said that certified nurse aide grabbed my arm, note indicates supervisor made aware, and outpatient radiology called again. Nurse note 5/17/11 12:00pm indicates R9 no complaints of pain, again staff indicating that outpatient radiology services called. Nurse note 5/17/11 3:00pm denotes R9 resting comfortably denies pain. Follow up with radiology endorsed to next shift. Nurse note 5/17/11 7:00pm indicates R9 radiology exam shows fracture, R9 physician notified and orders given for R9 to be transferred to the hospital for evaluation. On 8/5/11 at 10:00am via telephone E2 (director of nursing), said that when the attending physician is not reached the nursing staff are expected to notify the medical director, E2 said if the attending physician does not return call in over an hour then the medical director should be notified. E2 said that the facility don't have a policy guideline, but said it is the facility's practice to notify the medical director when the attending physician was not returning calls. E2 was unable to verbalize why after several unanswered pages from the attending physician, the nursing staff	F 157		

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F 157	Continued From page 5 didn't notify the medical director. According to the facility's change in condition or status the facility will promptly notify the attending physician of residents condition and / or status. The policy indicates the nurse will notify the attending physician when the resident is involved in any accidents or incidents that result in injury including injuries of unknown sources. The nurse will inform the attending physician when deemed necessary or appropriate in the best interest of the resident. According to the facility's pain management policy denotes the attending physician should be notified of a residents initial complaints of pain.	F 157		
F 223 SS=G	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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 interview and record review the facility failed to prevent staff from physically abusing 1 of 3 residents (R9) , reviewed for abuse in a sample of 3. This failure resulted in R9 sustaining a fracture to the left arm. Findings include:	F 223		10/31/11

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F 223	Continued From page 6 On 6/24/11 at 11:00am in the conference room, E2 (Director of Nursing), said R9 was assessed to be alert and oriented to person, place, and date. R9 said that about a month ago she was told by E18 to leave the dining room and that when she was getting up to leave E18 grabbed her left arm and bent it back. R9 said that "it really hurt when E18 pulled my arm back". R9 said she informed the nurse that E18 had hurt her arm and denied falling. Later R9 was transferred to the hospital for an evaluation after the incident occurred. The radiology report dated 5/17/11, exam left elbow and forearm denotes mild soft tissue swelling with limitation of flexion and what appears to be fracture of the medial epicondyle of the distal humerus with no significant displacement. Clinical correlation requested. On 6/24/11 at 1:15pm E2 said she called E18, E18 denied bending R9's left arm. E2 told her, that R9 was yelling in the dining room and he asked R9 to leave. E2 told E18 that R9 said that when she got up to leave he grabbed her arm and forced her out of the dining room. E18 denied the alligation. On 6/24/11 at 1:45pm, E6 (nurse) said on 5/16/11around 2:00pm while making rounds, R9 told her that her left arm was hurting, R9said E18 (CNA) hurt her arm twice while they were talking. E6 said that she didn't know what to think of what R9 had just told her, E6 said she left the room. Nursing notes dated 5/16/11 2:00pm indicates that R9 complained to the nurse that a CNA hurt my arm.	F 223		

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F 223	Continued From page 7 On 6/24/11 at 1:15pm that on R9 made an allegation that E18 bent her arm back. E2 said that she called E18 and E18 denied bending R9's arm. E2 said that E18 said that R9 was verbally yelling in the dining room and was asked to leave. E2 said that R9 said that when she got up to leave E18 grabbed her arm to force her out of the dining room. The facility's abuse policy denotes, physical abuse is the infliction of injury to a resident that occurs other than by accidental means and that requires medical attention. R9 sustained a fracture to the left arm as a result of force. E18's employee file the employee report indicates after a through investigation of the incident it was decided to terminate E18 employment.	F 223		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility staff failed to immediately notify the immediate supervisor and /or administrator of allegation of staff physical abuse made by 1 of 3 resident R9. The facility also failed to follow their abuse policy and immediately complete an incident report describing the assessment /description of an	F 226		10/31/11

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F 226	Continued From page 8 injury for 1 of 3 R9. Findings include: Nursing notes dated 5/16/11 2:00pm indicates R9 lying in bed comfortable. The note indicates that R9 complained to the nurse that a certified nurse aide hurt my arm. The note indicates upon assessment no redness, bruising, or swelling noted. The nurse note indicated when arm was touched R9 complained of pain. The note indicates that the physician was paged. Nurse notes 5/16/11 3:30pm denotes multiple bruise on the left arm, and leg. R9 again complained of pain at the left arm the note indicates that R9 was assessed as 8 of 10 on the pain scale (0 no pain -10 highest pain). The note indicates pain medication given at this time. The note indicates that R9 pain was reduced to 3 of 10 within 1 hour. Again the note indicates that the physician was paged. Nursing note 5/17/11 4:00am indicates R9 ambulating in the hallway, nurse note indicates bruising, redness and swelling to the left elbow and forearm. According to the facility's incident / accident report dated 5/17/11 4:00am indicates that R9 was observed ambulating in the hallway going to the shower. The report noted bruising, redness and swelling to the left elbow and forearm. R9's skin was noted to be warm to touch with no open areas noted. The incident report denotes that R9 said that certified nurse aid pulled her arm. R2 was assessed to be alert and oriented times 2. On 6/24/11 at 1:45pm E6(nurse), said that while making rounds on 5/16/11 around 2:00pm R9 told her that her left arm was hurting and that certified	F 226		

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F 226	Continued From page 9 nurses aid hurt her arm. E6 said that R9 told her twice in the same conversation that a cna (certified nurse aid) hurt her arm. E6 said that she didn't ask R9 who hurt her arm. E6 said that she didn't know what to think of what told to her by R9 and said that she left the room. E6 also said that she didn't obtain a comprehensive pain assessment after being told that R9s' left arm was hurting. E6 said that she failed to perform range of motion on R9 joint area of the left arm. E6 said that she look at R9's arm and noted no swelling or bruising, however when R9's arm was touched, E6 said R9 complained of pain. E6 said that she didn't adminster any pain medication, but said she endorsed the complaints of pain to the next shift. E6 said that after R9 told her that a cna hurt her arm, that she didn't inform her supervisor, or abuse coordinator. E6 said that she was unaware of the the facility's abuse policy. According to the facility's abuse policy employee are required to report any incidents, allegations or suspicion of potenial abuse they observe, hear about, or suspect to the administrator or an immidiate supervisor who must immediately report it to the administrator. The policy also indicates nursing staff is responsible for reporting on a facility incident report the appearence of suspicious bruises, lacerations or other abnormalties as they occur.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		10/31/11

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F 309	Continued From page 10 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct a comprehensive pain assessment and administer a prescribed as needed pain medication for 1 of 3 residents R9, R9 complained of pain to the left arm, R9's complaints of pain resulted in a fracture to R9's left arm. Based on interview, and record review the facility failed to assesses an post operative surgical abdominal wound and obtain treatment order for the wound, and failed to attach the wound dressing to continuous suction for 1 of 3 residents R13 in a sample of 3. The facility also failed to administer a physician prescribed psychotropic medication in a timely manner for 1 of 3 residents R13 in a sample of 3, R13 was admitted with a diagnosis of sever mental illness. Findings include: 1). Nursing notes dated 5/16/11 2:00pm indicates R9 lying in bed comfortable. The note indicates that R9 complained to the nurse that a certified nurse aide hurt my arm. The note indicates upon assessment no redness, bruising, or swelling noted. The nurse note indicated when arm was touched R9 complained of pain. The note indicates that the physician was paged. Nurse notes 5/16/11 3:30pm denotes multiple bruise on the left arm, and leg. R9 again complained of	F 309		

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F 309	Continued From page 11	F 309		

pain at the left arm the note indicates that R9 was assessed as 8 of 10 on the pain scale (0 no pain -10 highest pain). The note indicates pain medication given at this time. The note indicates that R9 pain was noted as reduced to 3 of 10 within 1 hour.

According to R9 physician order sheet dated May, 2011 denotes an order for acetaminophen 500mg, 2 tabs as needed for pain, the orders orgin was dated 1/7/2011.

On 6/24/11 at 1:45pm E6 (nurse), said that while making rounds on 5/16/11 around 2:00pm R9 told her that her left arm was hurting and that certified nurses aid hurt her arm. E6 said that R9 told her twice in the same conversation that a cna (certified nurse aid) hurt her arm. E6 said that she didn't ask R9 who hurt her arm. E6 said that she didn't know what to think of what told to her by R9 and said that she left the room. E6 also said that she didn't obtain a comprehensive pain assessment after being told that R9s' left arm was hurting. E6 said that she failed to perform range of motion on R9 joint area of the left arm. E6 said that she look at R9's arm and noted no swelling or bruising, however when R9's arm was touched, E6 said R9 complained of pain. E6 said that she didn't adminster any pain medication, but said she endorsed the complaints of pain to the next shift. E6 said that after R9 told her that a cna hurt her arm, that she didn't inform her supervisor, or abuse coordinator. E6 said that she was unaware of the the facility's abuse policy. E6 also said that paged the physician, but didn't get a return call, so the page was endorsed to the next nurse.

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F 309	Continued From page 12 According to the facility's pain management policy indicates the facility shall conduct a pain screen for pain if a residents experience a new onset of pain. The policy denotes if a residents scores 5 or more on the screening form the comprehensive pain assessment will then be completed. The policy indicates the physician will be informed of resident's initial complaint of pain. 2). According to R13 nurses notes dated 6/2/11 1:00pm indicates that R13 was admitted to the facility from a local hospital, The note indicates that R13 was assessed with a large abdominal wound covered with a Maxi pouch wound dressing with minimal amount of drainage noted. According to R13 ' s physician order sheet dated 6/3/11 denotes an order for the wound care nurse to follow R13 for wound management. On 8/30/11 at 2:30pm E13 (treatment nurse), said that she has been working at the facility as a certified wound care nurse for the last 8 years. E13 said that she never actually observed R13, however was consulted by E11 on care for a resident with the Maxi-Pouch wound dressing. E13 said that she was unaware of that type of wound dressing. E13 reviewed R13 ' s clinical record along with the survey team and said that she wasn ' t in the facility during R13 ' s admission, but said that after reviewing the physician orders that a nurse should have assessed R13 ' s wound, and notified the attending physician of R13 ' s present status for new treatment orders or continued treatment orders from the hospital. E13 said there should have been some note with the assessment of the wound and treatment orders along with a	F 309		

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(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 309	Continued From page 13 treatment administration record completed. A review of R13 ' s clinical record nurses notes along with E2 (director of nursing), E3 (assistant director of nursing), and Z3 (nurse consultant), on 8/30/11 during the daily status meeting. E2 was unable to locate any entries in the clinical record where R13 ' s wound was assessed, E3 said that there was no treatment record for R13 ' s open abdominal wound. The facility was unable to provide the survey team with treatment records or treatment orders for R13 ' s open wound and the Maxi -Pouch wound dressing. On 8/30/11 at E11 (nurse), said that she admitted R13 on 6/2/11. E11 said that R13 was assessed to have a Maxi-Pouch wound dressing. E11 said that she was unfamiliar with the Maxi-Pouch wound dressing. E11 said that she didn ' t look at and/or assess R13 ' s abdominal wound. E13 said that she didn ' t make the attending physician aware of the type of wound dressing that covered R13 ' s abdominal wound. E11 said she didn ' t get treatment orders for R13 ' s abdominal wound. E11 reviewed R13 ' s clinical record along with survey team, and said that it was wound care ' s responsibility to follow up and treat R13 ' s abdominal wound. E11 said that she faxed over R13 ' s medication requisition on 6/2/11, however E11 said that it is up to the pharmacy to obtain the physician authorization for psychotropic medications. E11 said that she didn ' t follow up with attending physician/pharmacy to ensure the authorization was signed, to expedite R13 ' s medication order was filled. A review of R13 ' s clinical record nurse notes there was no description or assessment of R13 '	F 309		

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F 309	Continued From page 14 s wound from 6/2/11 until discharge on 6/5/11, and there were no treatment record noted in R13 ' s clinical record. There was no orders for treatment noted on the physician order sheet. According to R13 ' s hospital record dated 6/1/11 indicates that R13 was status post colorectal surgery, and was going to be discharged to facility on 6/2/11. The hospital record indicates that the Maxi-Pouch wound dressing is connected to continuous wall suction at 125mm hg with 2 30 french catheters inside. The report denotes R13 ' s open wound to measure 8 inches x 11 inches. The report indicates that attempts were made to the facility to discuss the wound with the wound care nurse, but indicates the wound care nurse has not yet contacted the hospital for instructions for the Maxi-Pouch wound dressing. On 9/1/11 at 12:50pm via telephone E11 said that she admitted R13 on 6/2/11 and noted the maxi-Pouch dressing was in place, E11 said there were 2 drainage bags attached to the Maxi-Pouch. E11 said that she didn't connect the Maxi-Pouch to continuous wall suction at 125mm hg. E11 said that the facility don't have contiuous wall suction. E11 said that the Maxi-Pouch didn't require suction. 30. According to R13 ' s admitting physician orders indicates that R13 had medication orders for Trazadone (anti-depressant) 50mg daily, Risperadol (anti-psychotic)1.0mg twice a day, Lorazepam (anti-anxiety), 2.0mg daily, Escitalopram (anti-depressant), 20mg daily, Aprippriprazole (anti-psychotic) 10mg daily. According to the medication administration record	F 309		

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F 309	Continued From page 15 R13 was documented as receiving these psychotropic medications for the first time on 6/4/11, 2 days after R13 was admitted. According to the pharmacy shipment summary the outpatient pharmacy received the order for the mentioned medication on 6/2/10 and noted the order was filled on 6/2/11, except for the Lorazepam 2mg tab was filled on 6/3/11. On 8/30/11 at 4:00pm both E2/E3 were unable to verbalize why the nursing staff failed to dispense and administer R13 ' s scheduled psychotropic medications for 2 days. E2 said the expectation of nursing is to dispense and administer medication to residents as ordered. On 8/30/11 at 2:30pm E13 said that if pharmacy hasn ' t filled the order within the shift the nurse should follow up with pharmacy or the attending physician to determine the hold up. E13 said this follow should occur for all medication to include psychotropic medications.	F 309		
F 508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that outpatient radiology service provider, performed prescribed exam in a timely manner for 1 of 3 residents R9, R9 complained of	F 508		10/31/11

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F 508	Continued From page 16 pain was later assessed with a fracture. Findings include: Nursing notes dated 5/17/114:00am indicates that the outpatient radiology service has been contacted per physician orders. Nursing notes 5/17/11 7:00am denotes that nurse called the outpatient radiology service again. Nursing note 5/17/11 12:00pm denotes that E6 called the outpatient radiology service again, in regards to R9's left arm and elbow. Nursing note 5/17/11 3:00pm indicates an endorsement for the the next shift nurse to follow up with radiology. Nursing note 5/17/11 7:00pm indicates R9's x-ray has been taken with a result of a fracture to the left arm. According to the radiology report dated 5/17/11 exam left elbow and forearm denotes mild soft tissue swelling with limitation of flexion and what appears to be fracture of the medial epicondyle of the distal humerus with no significant displacement. Clinical correlation requested. According to the outpatient radiology report fax indicates the facility was notified of the result at 8:58pm. On 8/5/11 at 1:30pm E2 (director of nursing), said that the facility expect outpatient radiology to arrive to the facility within 1 to 2 hours after being notified. E2 said that if the outpatient radiology hasn't arrive within that time frame she would expect the nursing staff to contact the physician to make them aware.	F 508		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS:	F9999		

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F9999	Continued From page 17 : 300.3240a) 300.3240b) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) 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. Based on interview and record review the facility failed to prevent staff from physically abusing 1 of 3 residents (R9) , reviewed for abuse in a sample of 3. This failure resulted in R9 sustaining a fracture to the left arm. The facility staff also failed to immediately notify the immediate supervisor and /or administrator of allegation of staff physical abuse made by 1 of 3 resident R9. The facility also failed to follow their abuse policy and immediately complete an incident report describing the assessment /description of an injury for 1 of 3 R9. Findings include: On 6/24/11 at 11:00am in the conference room, E2 (Director of Nursing), said R9 was assessed to be alert and oriented to person, place, and date. R9 said that about a month ago she was told by E18 to leave the dining room and that when she was getting up to leave E18 grabbed	F9999		

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F9999	Continued From page 18	F9999		

her left arm and bent it back. R9 said that "it really hurt when E18 pulled my arm back". R9 said she informed the nurse that E18 had hurt her arm and denied falling. Later R9 was transferred to the hospital for an evaluation after the incident occurred.

The radiology report dated 5/17/11, exam left elbow and forearm denotes mild soft tissue swelling with limitation of flexion and what appears to be fracture of the medial epicondyle of the distal humerus with no significant displacement. Clinical correlation requested.

On 6/24/11 at 1:15pm E2 said she called E18, E18 denied bending R9's left arm. E2 told her, that R9 was yelling in the dining room and he asked R9 to leave. E2 told E18 that R9 said that when she got up to leave he grabbed her arm and forced her out of the dining room. E18 denied the alligation.

On 6/24/11 at 1:45 p.m., E6 (nurse) said on 5/16/11around 2:00 p.m. while making rounds, R9 told her that her left arm was hurting, R9 said E18 (CNA) hurt her arm twice while they were talking. E6 said that she didn't know what to think of what R9 had just told her, E6 said she left the room. E6 said that she looked at R9's arm and noted no swelling or bruising. E6 said that after R9 told her that a CNA hurt her arm, that she didn't inform her supervisor, or abuse coordinator. E6 said that she was unaware of the the facility's abuse policy. Nursing notes dated 5/16/11 2:00 p.m. indicates that R9 complained to the nurse that a CNA hurt my arm.

The facility's abuse policy denotes, physical

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F9999	Continued From page 19 abuse is the infliction of injury to a resident that occurs other than by accidental means and that requires medical attention. R9 sustained a fracture to the left arm as a result of force. According to the facility's abuse policy employee are required to report any incidents, allegations or suspicion of potenial abuse they observe, hear about, or suspect to the administrator or an immidiate supervisor who must immediately report it to the administrator. The policy also indicates nursing staff is responsible for reporting on a facility incident report the appearence of suspicious bruises, lacerations or other abnormalties as they occur. E18's employee file the employee report indicates after a through investigation of the incident it was decided to terminate E18 employment.	F9999		