STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145715	A. BUILDING _____ B. WING _____	10/28/2011

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WHEATON CARE CENTER	1325 MANCHESTER ROAD WHEATON, IL 60187

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. A validation survey for Subpart S: SMI	F 000		
F 174 SS=C	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation, record review and, interview the facility failed to provide a telephone where residents can make and receive private calls where they cannot be overheard. This has the potential to affect all 110 residents in the facility. Findings include: Residents were observed to talk on telephones in the middle of the hallways throughout the survey from 10/25/11 to 10/28/11. These were facility phones that had to go to through the switch board. Resident conversations could be heard by any one passing by or the residents in rooms near the telephone. After this was mentioned to E1 the administrator on 10/26/11, he said cordless phones would be purchased for residents to use. A work order dated 10/27/11 indicates that 3 cordless phones were ordered.	F 174		11/18/11
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		11/18/11

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

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F 242	Continued From page 1 schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to: - ensure residents have the right to choose the times they get up in the morning go to bed at night and the time they take their medication. - make choices about all aspects of their life that are significant to them. This is for 2 of 22 residents (R12 and R17) in the sample and eight other residents (R77, R85, R105, R58, R35, R110, R42 and R99) from the supplemental sample who attended Resident Group Meeting during the survey. Finding include: During the group meeting conducted 10/26/11 at 1:00p.m., ten residents were in attendance 10 of 10 states they are told they have to be in bed by 10:00p.m. The group states the Garden level game / TV room is locked and residents cannot watch the television or use the microwave after 10:00p.m. . Residents voiced concerns if they cannot sleep they would like to watch TV in the game room. The group said some residents do not have televisions in their room and facility staff is watching the television in the dining room.	F 242		

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F 242	Continued From page 2 A review of the resident council meeting for March, July and January 2011 residents addressed the rules about the facility's community passes in the field for transportation into the community. The response documented in the July 2011 Council minutes states: the caseworker response is " I do not know " and they do not offer to help the residents in figuring out any possible leads nor information to their request. During the group meeting, residents voiced it is still a concern. They do not know how the facility makes the determination for the out side pass increase or decrease. The group voiced concerns about being wakened up at 5:00a.m. Or 6:00a.m. In order to take medications, shower or just gotten up at that time. The residents states none of the staff asked them if they wanted to get up early or have their medications at the early hours.The interview with E2 (Director of Nursing) asked about the timing of the residents medications. A list of 52 residents was presented who receive multiple medications and treatments of Blood Sugar testing and Insulin administration done between 5 am-6 am. Breakfast is served at 7:30 a.m. in the garden level and 8:00a. on the main level. The Lex-Comp's Drug Reference Handbook 12 th edition patient information states: " ....with insulin Novolog you must start eating with in 5-10 minutes after injection and Lantus (Apidra) should be administered within 15 minutes before or with in 20 minutes after the start of the meal." The facility has identified six residents (R110, R8, R3, R31, R 28 and R35) who received some form	F 242		

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F 242	Continued From page 3 of insulin at 5 am - 6 am. There are 10 residents (R30, R44, R10, R57, R68, R5, R63, R56, R37 and R49) who get blood sugar testing. E2 she said there was not a reason that residents received early morning medications and the facility has no system for the determination. The facility had not asked the residents if the time was good for them.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to: (1) accommodate one resident who wished to go to an activity on the facility bus. (R13) (2) provide an electric razor for male residents including R17 who wanted to shave with an electric razor. (3) provide appropriate bed and incontinence products for R7 who has morbid obesity. (4) provide appropriate mattress for R72 This is for 3 of 22 residents (R13, R17 and R7) in sample and one resident (R72) from the supplemental sample with special needs.	F 246		11/18/11

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F 246	Continued From page 4 Findings include: On 10/27/11 at 2:00pm R13 said recently he was not allowed to go the movie theater because "walkers are not allowed on the bus." R13 said there is a $1.00 theater in the community the facility bus takes residents to a movie in the evenings. R13 said he used to go but " the big boss" said no one who uses a wheel chair or walker is allowed to go on the bus. R13 was observed to walk with a walker to the dining room and in the hallways on all days of the survey (10/25/11- 10/28/11). R13's restorative nursing program documentation dated 9/6/11 lists an order for ambulation - resident to be able to ambulate with a rolling walker with staff verbal cues and supervision. On 10/27/11 at 3:45pm E4 social service director said it is true R13 could not go on the bus because he was not able to step up to the entrance of the bus. No assistive device was used. R17 was in his room at 11:00 am on 10/25/11 noted with long whiskers on his face. R17 said he would like to shave with an electric razor but he does not have one. R17 said on 10/28/11 one of the staff brought an electric shaver from home for some of the residents to use. R17 said he can't use a razor blade because it irritates his face. The facility did not obtain residents preference for grooming. R7 who has morbid obesity was in a regular bed. R7, when she was in her bed has little room for her to turn. R7 who is alert and oriented to time,	F 246		

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F 246	Continued From page 5 place and person on 10/26/11 at 12:05 pm stated 'it would be nice if the bed is wider, but I told them it is okay, I don't want to be discharged.' R7 expressed she was concerned the facility may not take it well and discharge her. R72 is tall. She was in her bed, lying in diagonal position. R72 who is alert and oriented to time, place and person on 10/16/11 at 10:30 am stated she has been here in the facility for last at least six months in different rooms. R7 stated none of the rooms bed mattress is long enough to accommodate her height. At this time R72's Psychiatric Rehabilitation Service Counselor (PRSC) was present verified the mattress was too short for her.	F 246		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide safe, clean and comfortable environment. This is for both levels of the facility and has potential to affect all the residents in the facility. Findings include: On 10/25/11 during the initial tour of the facility	F 252		11/18/11

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F 252	Continued From page 6 surveyor observed the following: -A4 room closet door is broken. -B5 room curtains on windows off track. -B6 room sliding window is off track. -B6 closet door had splinters. This has potential for safety hazard. -B7 room Armour drawer track broken and the drawer is on the floor. -B7 complained of not having enough light to accommodate him for reading. -B7 room closet door has no knobs. -Room B8 closet door broken. -A wing hall ways were cluttered with weighing scales, med carts, linen hampers, and mechanical lifts. -A and B Hall community shower stalls are filthy, has mildew at wall and floor joints and tiles were cracked and has sharp edges. The bath mats were soiled and dirty. The bath rooms also had fecal odors. -Residents Council monthly meeting minutes and in group meeting held on 10/26/11 voiced complaints about shower rooms often had fecal smears and they are not clean. Residents also stated they do not like using showers for the same reason. Residents also stated the staff do not ensure the bath rooms are cleaned promptly after each resident using shower and the residents identified a particular Certified Nurse Aide (CNA). -On 10/26/11 surveyors observed flies and spiders on lower lower living area. On 10/28/11 roaches were seen on ceiling and wall joints and the maintenance manager verified the observation.	F 252		

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: Implement toilet plan of care and provide incontinence care to R 7. Provide an appropriate incontinence containment product for R 7. This is for one of 21 residents who are incontinent of bladder. As a result: R 7's developed skin alteration related to incontinence. R 7's expressed mental anguish because of her inability to receive incontinence care in timely manner and not having proper fitting incontinence product. Findings include: On 10-25-11 at 11:00 AM, the wound doctor stated " They (the facility-staff) asked me to evaluate her buttocks area. I requested them an	F 315		11/18/11

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F 315	Continued From page 8 hour ago to put R7 back in the bed so I could see her behind. They said that her aide (C.N.A.) went on break. " At 11:30AM, R 7 was observed in a motorized bariatric wheelchair, transferred via a mechanical lift by two CNA's from wheelchair to bed. The CNA's repositioned R 7 to her side and noted a thin disposable absorbent bed liner in between her legs observed to be soaked with urine. The CNA pulled down R 7's liner and noted to have a very strong Ammonia odor. R 7 was noted with whitish macerated area with multiple blister's that burst on her buttocks. The CNA , E 10, stated " because she's incontinent. " After the wound doctor examined R 7's skin alteration on her buttocks the two CNA's kept the same soaked liner on R 7. No perineal care was provided. R 7's incontinence plan of care reads: provide incontinent care after each incontinent episode and apply moisture barrier. These approaches were not followed on 10-25-11 at 11:30 AM. The bowel and bladder Coordinator (E16) said on 10-27-11, "she uses the orange incontinence absorbant liners." When E 16 was asked if the facility has a bariatric disposable adult incontinence garment, E 16 stated, " they have large diaper but it won't snap on the side. She's too big. " Then E 16 stated " I have to check if there's bariatric size. " On 10-28-11 at 12:30 PM, R 7 stated " thank you very much! They gave me a big diaper that fits me. I've been here for five months. They told me before told me there's no big diaper for me. You know how awful that is. I need to control my fluid intake so I don't wet my self that much. I'm very upset. You know how hard that is with the urine smell. I sacrificed and believed them. "	F 315		

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F 315	Continued From page 9 As a result R7 suffered from mental anguish.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide necessary care and services to manage a resident (R10) who is dependent on staff for his activities of daily living. This is for one of three residents (R10) in the facility who has gastrostomy tube (GT). Findings include: On 10/25/11 at 11:00 am R10 was in bed with his head of bed not elevated, his mouth and lips were dry, his face and hair was greasy. R10's GT feeding bottle (1000 cc) had a label that read the bottle was hung on 10/24/11 at 4:00 pm to infuse at 90 cc per hour. There was 300 cc of feeding left in the bottle on 10/25/11 at 11:00 am. There should have been a second bottle of feeding left with 350 cc of feeding left if the feeding was infused correctly. At this time two Certified Nurse	F 322		11/18/11

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F 322	Continued From page 10 Aides (CNAs) E12 and E13 came into the room, removed R10's wet diaper and applied a clean diaper, washed his face, elevated his head of the bed and left the room saying they will get him up later at 12:30 pm. E12 or E13 provided oral care for R10. R10 has physician orders: (1) 9/30/11 physician order stated 'elevate the head of the bed 30 to 45 degrees during feeding unless contraindicated. (2) Glucerna 90 cc per hour for 22 hours, off feeding 4:00 am to 6:00 am. The staff did not implement these physician orders. On 10/24/11 the survey team discussed the concern with the facility Director of Nurse (E2). E2 stated the Nurses labelled the wrong on the bottle and feeding was incorrect and E2 provided education to the nurses on correct infusion of GT feeding.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		11/18/11

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F 323	Continued From page 11 Based on observation, interview and record review the facility failed to: -Transfer a resident (R7) in the manner to avoid potential accident hazard. -Provide supervision to prevent resident to resident verbal and physical altercations. This is for three of 22 residents (R7, R17 and R22) in the sample and 12 residents (R24, R33, R37, R49, R59, R60, R74, R84, R91, R98, R104, and R110) from the supplemental sample. Findings include: 1. On 10/25/11 at 11:30 am E9, E10 and E11 Certified Nurse Aides (CNAs) transferred R7 with a total mechanical lift from her bed to motorized chair. R7 has morbid obesity, and totally dependent on staff for her activities of daily living. During the transfer the staff placed R7's motorized chair in the hall way; E10 and E11 had R7 in the sling; E9 operated the lift. After R7 in her sling reached the chair, she was too high in the air and did not land on the chair even after E9 lowered her in the lift to the maximum. At this point E9 lifted the mechanical lift to tilt R7 on to the motorized chair. In the process of E9 lifting the mechanical lift, there is great risk R7 could have been dropped to floor. On 10/25/11 at 11:45 am E9 stated he has been always transferring R7 from bed to wheel chair with a total mechanical lift and each time he had tilt the lift in order for him to place R7 in her chair. The mechanical lift operational manual recommended to use their brand weight appropriate size sling. The Restorative Nurse on 10/27/11 at 2:40 pm stated one size sling fits all.	F 323		

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F 323	Continued From page 12 R7's plan of care for falls and transfers did not determine the size of sling appropriate for R7. On 10/26/11 at 4:00 pm the survey team discussed the concern with the facility administration staff. 2. On 1/16/11 R22 11:30 am was watching Television (TV), another male resident came and changed TV channel. R22 got up set and hit the male resident on his back with his fist. It was note in the Occurrence Resolution to seek staff for assistance immediately. It was unclear how an impulsive behavior resident will seek staff assistance. The investigation do not indicate where the staff was during the occurrence. 3. On 2/3/11 at 1:45 pm R49 was under the influence of her delusions thinking she was the elevator operator. When R49 and R110 was in the elevator R110 pushed the button to the floor where he was going, R49 scratched R110 to prevent R110 to operate the elevator. The event investigation did not specify if R49's delusions were acute or chronic. The facility sent R49 for acute psychiatric hospitalization. When R49 returned to the facility no plan of care developed to deal with R49's delusions. 4. On 2/27/11 at 11:30 am R33 kicked R37's chair and said mean words. R37 got upset and threatened R33. 5. On 3/9/11 at 9:15 am R104 pushed R17 because R17 yelled at R104 for leaving bath room messy. R17 on 10/26/11 stated it happens all the time, staff do not care when reported such incidents.	F 323		

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F 323	Continued From page 13 6. On 3/20/11 at 5:30 pm R110 got upset during meals because of R98's talking continuously during dinner, got up and left to his room; and later R110 met R98 in hall way and kicked R98 in legs. The event report investigation did not include as to where the staff was or how such occurrences will be prevented. 7. On 6/29/11 at 2:20 pm R74 pushed R59 when R59 approached R74 to help with the vending machine. The facility sent R74 to hospital for evaluation. When R74 readmitted to the facility no change in the interventions noted to prevent further occurrences. 8. On 8/1/11 at 6:27 pm R91 hit R60 on back of her neck. Upon questioning R91 stated she thought R60 was talking about her even though R60 was sitting quietly in her wheel chair and not talking at all. The facility sent R91 for psychiatric hospitalization on 8/1/11, upon R91's returning to the facility no revised interventions were developed to avoid further occurrences. 9. On 10/19/11 12:15 pm R24 hit R84 with a milk carton when R84 stated he was going to marry her. The investigation reported had no information to indicate where the staff was. There were three other incidents of resident to resident altercations on 5/27/11, 7/4/11 and 7/27/11 involving the residents who are not at the facility.	F 323		
F 406 SS=E	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but	F 406		11/18/11

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F 406	Continued From page 14 not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to: Ensure the Psychiatric Rehabilitation Services Director (PRSD) and all staff are aware of residents who have or have history of high-risk behaviors. - Ensure the PRSD is made aware of residents who are refusing programming and that documentation and evaluations are available for the refusal. - Ensure the Level Of Functions (LOF) assessments indicates strengths, weaknesses, the priority level for programs to be initiated and which level of the skills programs the resident is to be started on. - Ensure the plans of care are specific to the assessed residents needs and the care plan goals and interventions are measurable. - Ensure residents and family (if applicable) is actively involved in the development of skills programs and the care plan process. - Coordinate out side program with the facility interdisciplinary team plan.	F 406		

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F 406	Continued From page 15 - Provide supervision to prevent resident to resident verbal and physical altercations. This is for six of eight residents (R2, R5, R6, R11, R17 and R18) in the sample of 22 residents and six residents (R91, R49, R110, R84, R122 and R86) from the supplemental sample who have severe mental illness. Findings Include: 1. R 5, a 45 years of age observed on 10 /25/11 in his room and through out the facility R5 appears disheveled unshaven and has a flat affect. Asked R5 what groups he attends, he stated he really did not attend any thing. A review of the 9/23/11 skills level of functioning (LOF) list R5 requires services in self-maintenance, social skills, symptom management, substance abuse management, community living skills and occupation skills A review of the group list R5 is scheduled for medication management skills training. A review of the plan of care dated 9/22/11 R5 exhibits physically abusive behaviors, refuses to take showers and has socially inappropriate behaviors with smoking. From interview with E4 Psychiatric Rehabilitation Services Director (PRSD) and E 14 Psychiatric Rehabilitation Services counselor (PRS) the LOF does not identify the strength and weakness or how the assessment is prioritized to determine what level of skills training R5 is a candidate for or what skills concerns the team will address first and why.	F 406		

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2. R6, a 39 year old female observed on 10/25/11 at 11:00a.m. In bed said, she has not been feeling well. R6 states her tooth has been hurting for a while and she was waiting to see the dentist on November 4th 2011. R5 appeared disheveled and unkempt. The surveyor asked R5 if she attends any groups. R5 stated sometimes she does but not while her tooth is hurting. A review of the group list R5 is scheduled for the independent living group and coping group.

A review of the LOF dated 10/26/11 lists concerns for self-maintenance, social skills, symptom management substance abuse management, community living skills and occupation skills the assessment does not list the strength and weakness for R6. There is no prioritization of which groups and level to start R6.

E4 said, about the programs listed for the residents, the facility currently only has one level of basic groups running.

3. On 10/27/11 at 3:25 pm R18 was in his room. During the visit on 10/27/11 at 3:25pm. R18 said he goes to a day program in the mornings during the week for several hours. E4 psychiatric rehabilitation service director (PSRD) said on 10/28/11 there are three residents in the facility who attend off site day programs. E4 also said

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F 406	Continued From page 17 the facility does not receive any feedback from the day program. There was no assessment to indicate which of the identified goals and objective will be accomplished with R18's participation in off site day program. Review of R18's care plan dated 10/25/11 shows there is no care plan for the day program. 4. On 10/26/11 R11 was in bed listing to music when visited in the afternoon. According to the in house group assignments presented during the survey, R11 is not assigned to attend any specific group. The psychosocial well being, skills / level of functioning observation form completed on 8/24/11 lists areas in self-maintenance, social skills, symptoms managements skills, substance abuse management , community living skills , and occupational skills. The facility scores the resident level from 1 to 5 with 1 being highly typical/ always to 5 being highly atypical/never. R11's overall rehabilitation level score was 115 which states = high rehabilitation level/ discharge potential. The skills level of functioning assessment indicated that R18 has employable skills (significant work experience, training or education). The facility did not identify R11's strengths and weaknesses, no priority of the problems identified based on his skill level of functioning assessment. 5. Review of R2's event report of 6/4/11 R2 multiple diagnoses including Schizoaffective Disorder and Anxiety state. Per the event report notes, R2 was assessed as being alert and oriented, ambulatory and requiring supervision in	F 406		

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F 406	Continued From page 18 activities of daily living. On 10/25/11 reviewed an incident, "Event Report" dated 6/4/11 regarding R2. The report read , that on 6/4/11 at 9:59 a.m. R2 hit a CNA after closing his window. The note documented R2 was queried why he hit the staff, R2 stated, she was starting up with me". R2 was asked what the statement meant. R2 said ,"she closed the window, and I'll do whatever I want ". The staff R2 was told that the CNA closed the window in order to keep the temperature in his room to a comfortable level". E4 PRSD was queried on 10/26/11, about the occurrences surrounding the incident where R2 became aggressive toward a CNA on 6/4/11 due to wanting his window opened. E4 was queried whether R2 had a history in the facility of the behavior observed on 6/4/11. E4 was queried to review R2's behavioral care plan. E4 stated that R2 had not exhibited this type of behavior before in the facility. E4 was queried as to why the CNA closed R2's window when R2 requested it be left opened. E4 stated she believed the humidity was high, but was unsure of the temperature. Z 4 (nurse practitioner) visited resident on 10/26/11. Z4 stated during the interview that R2 has terminal lung Disease (very bad lungs) and difficulty breathing. Z4 stated she recalled it being very hot in the facility at least six months prior and requested a fan for him. R2 did not receive the fan as of yet. Review of R2's care plan was done on 10/26/11. There were two care plans one dated 6/8/11 that	F 406		

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read, R2 rates low risk based on aggression assessment,,, based on incident of 6/4/11, R2 hitting CNA (certified nursing assistant) on the shoulder he has the potential for aggression. The second care plan initiated 3/06/11, was based on criminal history analysis from 1986 through 1994. The goal of the plan was for R2 not to demonstrate inappropriate behaviors ... not limited to physical aggression or battery through next review. An approach for this goal read, " when resident is exhibiting periods of increased agitation, and becomes physically abusive, redirect and remove resident from area to avoid increased stimulation and to decrease potential for resident to physically act out. Keep distance between resident and others." The staff did not follow these interventions on 6/4/11.

There were no documented behaviors prior to or after the event of 6/4/11. The facility attempted to send R2 to a hospital behavioral unit to seek emergency psychiatric rehabilitation two times. When the hospital denied of R2's admission to hospital, the facility determined to keep R2 in the facility. The facility failed to evaluate the staff proficiency to intervene to decrease undesirable behavior instead the facility obtained psychiatrist order to seek emergency psychiatric hospitalization for R2.

The facility sent the following resident to resident altercations incidents to the Department:

6. On 1/16/11 R22 11:30 am was watching Television (TV), another male resident came and changed TV channel. R22 got up set and hit the male resident on his back with his fist. It was note

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in the Occurrence Resolution to seek staff for assistance immediately. It was unclear how an impulsive behavior resident will seek staff assistance. The investigation do not indicate where the staff was during the occurrence.

7. On 2/3/11 at 1:45 pm R49 was under the influence of her delusions thinking she was the elevator operator. When R49 and R110 was in the elevator R110 pushed the button to the floor where he was going, R49 scratched R110 to prevent R110 to operate the elevator. The event investigation did not specify if R49's delusions were acute or chronic. The facility sent R49 for acute psychiatric hospitalization. When R49 returned to the facility no plan of care developed to deal with R49's delusions.

8. On 2/27/11 at 11:30 am R33 kicked R37's chair and said mean words. R37 got upset and threatened R33.

9. On 3/9/11 at 9:15 am R104 pushed R17 because R17 yelled at R104 for leaving bath room messy. R17 on 10/26/11 stated it happens all the time, staff do not care when reported such incidents.

10. On 3/20/11 at 5:30 pm R110 got upset during meals because of R98's talking continuously during dinner, got up and left to his room; and later R110 met R98 in hall way and kicked R98 in legs. The event report investigation did not include as to where the staff was or how such occurrences will be prevented.

11. On 6/29/11 at 2:20 pm R74 pushed R59 when R59 approached R74 to help with the vending

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F 406	Continued From page 21	F 406		

machine. The facility sent R74 to hospital for evaluation. When R74 readmitted to the facility no change in the interventions noted to prevent further occurrences.

12. On 8/1/11 at 6:27 pm R91 hit R60 on back of her neck. Upon questioning R91 stated she thought R60 was talking about her even though R60 was sitting quietly in her wheel chair and not talking at all. The facility sent R91 for psychiatric hospitalization on 8/1/11, upon R91's returning to the facility no revised interventions were developed to avoid further occurrences.

13. On 10/19/11 12:15 pm R24 hit R84 with a milk carton when R84 stated he was going to marry her. The investigation reported had no information to indicate where the staff was.

There were three other incidents of resident to resident altercations on 5/27/11, 7/4/11 and 7/27/11 involving the residents who are not at the facility.

The facility presented a list of 54 residents who eligible for Subpart S services. Seven of 16 residents (R91, R49, R110, R17, R84, R122 and R86) involved in the altercations have severe mental illness and the other nine residents (R24, R33, R37, R59, R60, R74, R84, R98 and R104) without mental illness.

The facility quality assurance team did not analyze these resident to resident verbal and physical altercations to determine why the altercations occurred; or how the facility will ensure to decrease the undesirable behaviors.

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F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide at least 80 square feet per resident in multiple resident bedroom in 15 of 45 rooms. This has the potential to affect 51 residents in the facility which has a license capacity for 120 residents. Findings include: Rooms A22, A24, A28, A30, A31, A32, A33 and A34 set to provide occupy for three residents, which provides 74 square feet per resident. Rooms A18, A19, B2, B3, B7 and B8 set to provide occupy for 4 residents which provides approximately 78 square feet per resident. R7 who has morbid obesity lives in room A22 along with two other residents. R7 uses a motorized bariatric chair, needs total assistance with her activities of daily living and needs a mechanical lift to transfer her. On 10/25/11 at 11:30 am three Certified Nurse Aides (CNAs) E9, E10 and E11 transferred R7 with a total mechanical lift. During the transfer the staff parked R7's chair in hall way. There was not enough space have R7's chair, a mechanical lift, three CNAs and two beds for two other residents.	F 458		11/18/11

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F 458	Continued From page 23 The survey team discussed the concern with the facility administration staff. On 10/27/11 the facility transferred R7 to another room to share with another resident. If the facility is fully occupied this option was not possible.	F 458		
F 461 SS=E	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced	F 461		11/18/11

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F 461	Continued From page 24 by: Based on observation and interview, the facility failed to have the floor in residents rooms in the garden level at or above grade level. This applies to residents : 89, 90, 6, 91, 11, 92, 93, 94, 95, 96, 5, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 20, 108, 109, 110, 111, 17, 112, 113, 114, 115, 116, 117, 118, 119, 18, 120, 121, and 122. Findings include: Rooms in the garden level: B1, B2, B3, B4, B5, B6, B7, B8, B9, B10, B11, B12, B13, and B14 all are above grade level. E8 maintenance director toured this level with surveyor on 10/28/11. Each room is approximately 3 feet below grade level as measured by E8. According to residents R115, 97, 17, 107, 110 the facility floods several times a year when it rains a lot. the water covers the room floors and anything on the floor gets wet. E8 said the sump pump does not keep up with the rain.	F 461		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210c) 300.1210d)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	F9999		

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F9999	Continued From page 25 procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a	F9999		

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F9999	Continued From page 26 resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to: -Supervise R 9 who was identified as high risk for falls. -Develop and implement an aggressive preventative fall plan of care for R 9. -Revise & implement an individualize plan specific for R 9. -Follow doctor's order and plan of care to apply left leg immobilizer for R 9. -Thoroughly investigate the root cause of R 9's development of swelling of left knee and yellowish, brown discoloration to inner thigh area. -Transfer a resident (R7) in the manner to avoid potential accident hazard. -Provide supervision to prevent resident to resident verbal and physical altercations. Findings include: -R 9 sustaining a transverse impacted supracondylar fracture of the distal femur on	F9999		

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F9999	Continued From page 27 7/11/11. -Eleven episodes of resident to resident verbal / physical altercations have occurred. -There were three other incidents of resident to resident altercations on 5/27/11, 7/4/11 and 7/27/11 involving the residents who are not at the facility. This is for four of 22 residents (R7, R9, R17 and R22) in the sample and 12 residents (R24, R33, R37, R49, R59, R60, R74, R84, R91, R98, R104, and R110) from the supplemental sample. 1. On 10-25-11 at 11:10 AM, R 9's noted in bed with left foot resting on top of the right leg, with visible foot drop on the left foot. No orthotic foot support device was noted. On 10-25-11 at 11:15 AM, the CNA (E 10) stated " he's non-verbal. He has paralysis on one side (left) of the body. He doesn't use any splint or braces. He needs total care." On 10-26-11 at 10:30 AM, R9 was observed in the hallway sitting in an adult reclining chair. E 10 stated " He's transferred with a mechanical lift with two to three staff assistance. He doesn't like too many people caring for him, he fights more, yells out and he grabs on staff during care. I do better when I ' m alone, I think he cooperates more. " R 9's resident progress notes dated 07-11-11 at 11:20 PM read: Event: noticed right leg warm to touch and swollen ... 11:45 PM, noted to be in increase pain during assessment ... send R 9 to hospital for evaluation and treatment ... 07-12-11 showed R 9 was diagnosed with distal femur fracture. Soft mold cast from left hip to toe ... On 07-15-11 at 7:44 PM, R 9's progress notes	F9999		

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showed R 9 was sent to the emergency room for critical level of hemoglobin.

R 9 ' s musculoskeletal event dated 07-11-11 description: resident with swelling to left knee and yellowish-brown discoloration to inner thigh area..

R 9's History and Physical from the hospital, with the admission date of 07-15-11 reads: This is an unfortunate 52 year old male who has a history of traumatic brain injury from a motor vehicle accident which left him aphasic & bedridden with left hemiparesis. .. He is mainly moaning and groaning and at times is combative ... Of note, the patient (R9) was seen in the emergency room four days ago, reportedly had fallen at the nursing home. At the time, x-ray of the hip shows a supracondylar fracture on the left ... R 9 ' s portable x-ray results dated 07-27-11 reveals a transverse impacted supracondylar fracture of the distal femur.

Review of the facility incident report form showed reportable event occurred description of occurrence reads: (R 9) was observed to have yellowish brown discoloration on the right inner thigh, right knee also with slight swelling ... Unable to give an account or description of injury related to disease process ... Occurrence resolution: (R9) was seen by Orthopedic doctor, right leg cast was changed into soft brace for non surgical management of fracture. There was no thorough investigation conducted by the facility and this was confirmed by the Director of Nursing (E 2) on 10-27-11 at 12:10 PM. E2 also could not explain if R9 had a fall four days prior to his hospitalization as noted in 7/15/11 ER report.

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There was no aggressive preventative plan of care developed for R 9's. The care plan showed: (R9) at risk for falls related to medication profile and disease process. R9 has history of falls while up in chair ... The approach includes: analyze falls, ensure proper positioning (nurse's notes dated 10-19-11, R 9's foot was caught on the reclining chair foot rest) while up in chair. A mat should be in place while in bed. The call light in reach at all times (unable to use call light due diagnosis of brain injury), labs as order, mediation regimen review, praise resident with all efforts of complying with all prevention program, provide incontinency care every two hours and as needed.

Review of the plan of care dated 08-07-11 thru 01-20-12, presented by the facility Care Plan Coordinator reads: resident (R 9) has left leg immobilizer related to fracture of the left distal femur. These interventions are generalized.
2. On 10/25/11 at 11:30 am E9, E10 and E11 Certified Nurse Aides (CNAs) transferred R7 with a total mechanical lift from her bed to motorized chair. R7 has morbid obesity, and totally dependent on staff for her activities of daily living. During the transfer the staff placed R7's motorized chair in the hall way; E10 and E11 had R7 in the sling; E9 operated the lift. After R7 in her sling reached the chair, she was too high in the air and did not land on the chair even after E9 lowered her in the lift to the maximum. At this point E9 lifted the mechanical lift to tilt R7 on to the motorized chair. In the process of E9 lifting the mechanical lift, there is great risk R7 could have been dropped to floor.

On 10/25/11 at 11:45 am E9 stated he has been

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always transferring R7 from bed to wheel chair with a total mechanical lift and each time he had tilt the lift in order for him to place R7 in her chair.

The mechanical lift operational manual recommended to use their brand weight appropriate size sling. The Restorative Nurse on 10/27/11 at 2:40 pm stated one size sling fits all. R7's plan of care for falls and transfers did not determine the size of sling appropriate for R7.

On 10/26/11 at 4:00 pm the survey team discussed the concern with the facility administration staff.

3. On 1/16/11 R22 11:30 am was watching Television (TV), another male resident came and changed TV channel. R22 got up set and hit the male resident on his back with his fist. It was note in the Occurrence Resolution to seek staff for assistance immediately. It was unclear how an impulsive behavior resident will seek staff assistance. The investigation do not indicate where the staff was during the occurrence.

4. On 2/3/11 at 1:45 pm R49 was under the influence of her delusions thinking she was the elevator operator. When R49 and R110 was in the elevator R110 pushed the button to the floor where he was going, R49 scratched R110 to prevent R110 to operate the elevator. The event investigation did not specify if R49's delusions were acute or chronic. The facility sent R49 for acute psychiatric hospitalization. When R49 returned to the facility no plan of care developed to deal with R49's delusions.

5. On 2/27/11 at 11:30 am R33 kicked R37's

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chair and said mean words. R37 got upset and threatened R33.

6. On 3/9/11 at 9:15 am R104 pushed R17 because R17 yelled at R104 for leaving bath room messy. R17 on 10/26/11 stated it happens all the time, staff do not care when reported such incidents.

7. On 3/20/11 at 5:30 pm R110 got upset during meals because of R98's talking continuously during dinner, got up and left to his room; and later R110 met R98 in hall way and kicked R98 in legs. The event report investigation did not include as to where the staff was or how such occurrences will be prevented.

8. On 6/29/11 at 2:20 pm R74 pushed R59 when R59 approached R74 to help with the vending machine. The facility sent R74 to hospital for evaluation. When R74 readmitted to the facility no change in the interventions noted to prevent further occurrences.

9. On 8/1/11 at 6:27 pm R91 hit R60 on back of her neck. Upon questioning R91 stated she thought R60 was talking about her even though R60 was sitting quietly in her wheel chair and not talking at all. The facility sent R91 for psychiatric hospitalization on 8/1/11, upon R91's returning to the facility no revised interventions were developed to avoid further occurrences.

11. On 10/19/11 12:15 pm R24 hit R84 with a milk carton when R84 stated he was going to marry her. The investigation reported had no information to indicate where the staff was.

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There were three other incidents of resident to resident altercations on 5/27/11, 7/4/11 and 7/27/11 involving the residents who are not at the facility.

300.4010a)

Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs.

These Regulations were not met as evidenced by:

Based on observation, record review and staff interview the facility.

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Ensure that all staff is aware of residents who have or have history of high-risk behaviors.
- Ensure the staff is made aware of residents who are refusing programming and that documentation and evaluations are available for the refusal.
- Ensure the Level Of Functions (LOF) assessments indicates strengths, weaknesses, the priority level for programs to be initiated and which level of the skills programs the resident is to be started on.
- Ensure the plans of care are specific to the assessed residents needs and the care plan goals and interventions are measurable.
- Ensure residents and family (if applicable) is actively involved in the development of skills programs and the care plan process.
- Coordinate out side program with the facility interdisciplinary team plan.
- Provide supervision to prevent resident to resident verbal and physical altercations.

The facility quality assurance team did not analyze these resident to resident verbal and physical altercations to determine why the altercations occurred; or how the facility will ensure decrease the undesirable behaviors.

This is for six of eight residents (R2, R5, R6, R11, R17 and R18) in the sample of 22 residents and six residents (R91, R49, R110, R84, R122 and R86) from the supplemental sample who have severe mental illness.

Findings Include:

1. R 5, a 45 years of age was observed on 10

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F9999	Continued From page 34 /25/11 in his room and through out the facility R5 appears disheveled unshaven and has flat affect. Asked R5 what groups he attends, he stated he really did not attend any thing. A review of the 9/23/11 skills level of functioning (LOF) list R5 requires services in self-maintenance, social skills, symptom management, substance abuse management, community living skills and occupation skills A review of the group list R5 is scheduled for medication management skills training. A review of the plan of care dated 9/22/11 R5 exhibits physically abusive behaviors, refuses to take showers and has socially inappropriate behaviors with smoking. From interview with the LOF does not identify the strength and weakness or how the assessment is prioritized to determine what level of skills training R5 is a candidate for or what skills concerns the team will address first and why. 2. R6, a 39 year old female observed on 10/25/11 at 11:00a.m. In bed said, she has not been feeling well. R6 states her tooth has been hurting for a while and she was waiting to see the dentist on November 4th 2011. R5 appeared disheveled and unkempt. The surveyor asked R5 did she attend any groups, R5 stated sometimes she does but not while her tooth is hurting. A review of the group list R5 is scheduled for the independent living group and coping group. A review of the LOF dated 10/26/11 lists concerns for self-maintenance, social skills, symptom management substance abuse management, community living skills and occupation skills the assessment does not list the	F9999		

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strength and weakness for R6. There is no prioritization of which groups and level to start R6.

Interview with E4 about the programs listed for the residents E4 states the facility currently only has one level of basic groups running.

3. On 10/27/11 at 3:25 pm R18 was in his room. During the visit on 10/27/11 at 3:25pm. R18 said he goes to a day program in the mornings during the week for several hours. E4 psychiatric rehabilitation service director (PSRD) said on 10/28/11 that there are 3 residents in the facility who attend off site day programs. E4 also said the facility does not receive any feedback from the day program. There was no assessment to indicate which of the identified goals and objective will be accomplished with R18's participation in off site day program. Review of R18's care plan dated 10/25/11 shows there is no care plan for the day program.

4. On 10/26/11 R11 was in bed listing to music when visited in the afternoon. According to the in house group assignments presented during the survey, R11 is not assigned to attend any specific group. The psychosocial well being, skills / level of functioning observation form completed on 8/24/11 lists areas in self-maintenance, social skills, symptoms managements skills, substance abuse management , community living skills , and occupational skills. The facility scores the resident level from 1 to 5 with 1 being highly typical/ always to 5 being highly atypical/never. R11's overall rehabilitation level score was 115 which states = high rehabilitation level/ discharge potential. The skills level of functioning assessment indicated that R18 has employable

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skills (significant work experience, training or education). The facility did not identify R11's strengths and weaknesses, no priority of the problems identified based on his skill level of functioning assessment.

5. Review of R2's event report of 6/4/11 R2 multiple diagnoses including Schizoaffective Disorder and Anxiety state. Per the event report notes, R2 was assessed as being alert and oriented, ambulatory and requiring supervision in activities of daily living.

On 10/25/11 reviewed an incident, "Event Report" dated 6/4/11 regarding R2. The report read , that on 6/4/11 at 9:59 a.m. R2 hit a CNA after closing his window. The note documented R2 was queried why he hit the staff, R2 stated, she was starting up with me". R2 was asked what the statement meant. R2 said ,"she closed the window, and I'll do whatever I want ". The staff R2 was told the CNA closed the window in order to keep the temperature in his room to a comfortable level".

E4 PRSD was queried on 10/26/11, about the occurrences surrounding the incident where R2 became aggressive toward a CNA on 6/4/11 due to wanting his window opened. E4 was queried whether R2 had a history in the facility of the behavior observed on 6/4/11. E4 was queried to review R2's behavioral care plan. E4 stated R2 had not exhibited this type of behavior before in the facility.

E4 was queried as to why the CNA closed R2's window when R2 requested it be left opened. E4

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stated she believed the humidity was high, but was unsure of the temperature. Z 4 (nurse practitioner) visited resident on 10/26/11. Z4 stated during the interview that R2 has terminal lung Disease (very bad lungs) and difficulty breathing. Z4 stated she recalled it being very hot in the facility at least six months prior and requested a fan for him. R2 did not receive the fan as of yet.

Review of R2's care plan was done on 10/26/11. There were two care plans one dated 6/8/11 that read, R2 rates low risk based on aggression assessment,,, based on incident of 6/4/11, R2 hitting CNA (certified nursing assistant) on the shoulder he has the potential for aggression. The second care plan initiated 3/06/11, was based on criminal history analysis from 1986 through 1994. The goal of the plan was for R2 not to demonstrate inappropriate behaviors ... not limited to physical aggression or battery through next review. An approach for this goal read, " when resident is exhibiting periods of increased agitation, and becomes physically abusive, redirect and remove resident from area to avoid increased stimulation and to decrease potential for resident to physically act out. Keep distance between resident and others." The staff did not follow these interventions on 6/4/11.

There were no documented behaviors prior to or after the event of 6/4/11. The facility attempted to send R2 to a hospital behavioral unit to seek emergency psychiatric rehabilitation two times. When the hospital denied of R2's admission to hospital, the facility determined to keep R2 in the facility. The facility failed to evaluate the staff proficiency to intervene to decrease undesirable

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behavior instead the facility obtained psychiatrist order to seek emergency psychiatric hospitalization for R2.

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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
F9999	Continued From page 40 hospitalization for R2. 6. On 1/16/11 R22 11:30 am was watching Television (TV), another male resident came and changed TV channel. R22 got up set and hit the male resident on his back with his fist. It was note in the Occurrence Resolution to seek staff for assistance immediately. It was unclear how an impulsive behavior resident will seek staff assistance. The investigation do not indicate where the staff was during the occurrence. 7. On 2/3/11 at 1:45 pm R49 was under the influence of her delusions thinking she was the elevator operator. When R49 and R110 was in the elevator R110 pushed the button to the floor where he was going, R49 scratched R110 to prevent R110 to operate the elevator. The event investigation did not specify if R49's delusions were acute or chronic. The facility sent R49 for acute psychiatric hospitalization. When R49 returned to the facility no plan of care developed to deal with R49's delusions. 8. On 2/27/11 at 11:30 am R33 kicked R37's chair and said mean words. R37 got upset and threatened R33. 9. On 3/9/11 at 9:15 am R104 pushed R17 because R17 yelled at R104 for leaving bath room messy. R17 on 10/26/11 stated it happens all the time, staff do not care when reported such incidents. 10. On 3/20/11 at 5:30 pm R110 got upset during meals because of R98's talking continuously during dinner, got up and left to his room; and later R110 met R98 in hall way and kicked R98 in	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145715	A. BUILDING _____ B. WING _____	10/28/2011

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WHEATON CARE CENTER	1325 MANCHESTER ROAD WHEATON, IL 60187

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F9999	Continued From page 41	F9999		

legs. The event report investigation did not include as to where the staff was or how such occurrences will be prevented.

11. On 6/29/11 at 2:20 pm R74 pushed R59 when R59 approached R74 to help with the vending machine. The facility sent R74 to hospital for evaluation. When R74 readmitted to the facility no change in the interventions noted to prevent further occurrences.

12. On 8/1/11 at 6:27 pm R91 hit R60 on back of her neck. Upon questioning R91 stated she thought R60 was talking about her even though R60 was sitting quietly in her wheel chair and not talking at all. The facility sent R91 for psychiatric hospitalization on 8/1/11, upon R91's returning to the facility no revised interventions were developed to avoid further occurrences.

13. On 10/19/11 12:15 pm R24 hit R84 with a milk carton when R84 stated he was going to marry her. The investigation reported had no information to indicate where the staff was.

The facility presented a list of 54 residents who eligible for Subpart S services. Seven of 16 residents (R91, R49, R110, R17, R84, R122 and R86) involved in the altercations have severe mental illness and the other nine residents (R24, R33, R37, R59, R60, R74, R84, R98 and R104) without mental illness.

There were three other incidents of resident to resident altercations on 5/27/11, 7/4/11 and 7/27/11 involving the residents who are not at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 42 (B)	F9999		