

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(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 441	Continued From page 25 personnel on 3/28/2013 at 1:30 PM, five newly hired employee did not have two step testing as per the facility's: 8/12/2012, INFECTION CONTROL: TUBERCULOSIS TESTING: ITEMS: # 1,2,3,AND 4. 1. Employees receive a TB skin test when two days prior to the first day of orientation. 2. The skin test is read 48-72 hours after administration 3. If the first test is negative, the second step TB skin test is given 1-3 weeks later. Failure to complete the second step will result in the removal from the schedule. 4. A single step test is given annually thereafter. The five files reviewed only had one step TB results. Interview with E27 on 3/28/2013 at 1:30 pm states she was not aware that new staff are to have a two step testing. Interview with (E2) Director of Nursing who states she is in charge of infection control on 3/29/2013 at 2:30pm states she was not aware staff was not giving a two step TB testing.	F 441			
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a 300.1210b)4) 300.3240a)	F9999			

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F9999	<p>Continued From page 26</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and 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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide a more dignified manner of assisting one of one sampled resident (R 12) during toileting needs in the sample of 24</p> <p>This failure resulted in mental and psychosocial distress to R 12. R 12 claimed, " it's humiliating, demeaning and depressing " to have a bowel movement while in bed and on side lying position.</p>	F9999			

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F9999	<p>Continued From page 28</p> <p>Findings include: On 03-28-13 at 12:50 PM, R 12 was observed sitting on her wheelchair alone in the unit -dining room. R 12 was identified by staff as alert and oriented, can verbalize needs and transfer via a mechanical lift with two person assistance. At 1:00 PM, R 12 was taken to her room for dressing change, R 12 told the staff " I want to do #2 (bowel movement). " R 12 was observed transferred from her wheelchair to bed using a total mechanical lift. She was turned on her left side and was told by the two CNAs, " Let us know when you ' re done. " At 3:00 PM, R 12 stated, " That's one of my problems here., They get up so early, dress me up right away and if I had to have # 2 (BM) they even hurry you up. It's demeaning and very humiliating to do #2 while in bed. It is very hard to do that (do # 2 while in bed."</p> <p>On 03-28-13 at 10:25 AM, R 12 claimed, " They make me do # 2 while in bed. They don' t take me to the bathroom: If I wanted to use the bathroom they put me back to bed. They lie me down and turn me on the side. I have diaper on so they told me to just do it in my diaper. It is embarrassing. At the beginning it's very hard on me. I can't do it specially doing it while you're side lying? They said I can't use the toilet because of my sore in my tail bone. I'm telling you it's depressing and humiliating. It's very hard but what could I do? "</p> <p>On 03-29-13 at 2:25 PM, the Director of Nursing (E 2) and the Nurse Consultant (E1) was notified about R 12's statement and concern: E 2 stated, " She's a mechanical lift transfer. We put a disposable pad underneath her. " When the Administrative staff (E1 and E 2) were asked if there was a Physical Therapy referral done to</p>	F9999			

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F9999	<p>Continued From page 29</p> <p>evaluate appropriate system to assist R12 in her toileting needs, E 2 stated, " No, there were no referrals done and no, we didn't evaluate her for other alternatives. "</p> <p>On 03-29-13 at 10:30 AM, the Physical Therapy Aide (E 21) was informed about these findings (the assigned Physical Therapy person was on vacation at this time), E 21 stated she would discuss this information with the other Rehab staff and will evaluate R 12. At 1:25 PM, the Physical Therapy person stated, " We evaluated her and prescribed a bariatric bed pan for her. I think this would be better for her because it' softer for her back and more flexible. "</p> <p style="text-align: right;">(B)</p> <p>300.610a)</p> <p>300.1210d)5)</p> <p>300.1220b)3)</p> <p>300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and</p>	F9999			

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F9999	<p>Continued From page 30</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p>	F9999			

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F9999	Continued From page 31 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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:	F9999			

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F9999	Continued From page 32 Based on observation, interview and record review, the facility failed to identify the correct (a) location (sacrum versus coccyx) and (b) Stage (Stage III from Unstageable) of R 12 ' s pressure ulcers. The facility also failed to analyze R 12's tissue tolerance in order to develop and implement a more specific repositioning plan to promote healing , to stabilize or reduce R 12's underlying risk factors and co morbidities. The facility failed to evaluate and revise R 12 ' s care plan based on the identified needs and outcome. This applies to one (R 12) of two residents reviewed for pressure ulcer in the sample of 24. These failures resulted in the decline of R 12's pressure ulcers on her (1) coccyx from Stage III to Unstageable and (2) R 12's right hip from a Deep Tissue Injury to Unstageable pressure ulcer. Findings include: On 03-27-13 at 1:00 PM, R 12 was observed during dialysis treatment sleeping. The Dialysis staff identified R 12 as alert and oriented X 3 (with no cognitive problem), able to verbalize needs and needing the assistance of two during transfer using a mechanical lift. The staff stated, " We reposition her if she asks. She can verbalize her needs. " Review of the pressure ulcer report listed R 12 with three pressure ulcers (1) coccyx (2) right hip and (3) right medial toe. On 03-28-13 at 3:00 PM, R 12 said, " The sores started in the hospital but it didn't help here neither. It's healing too slowly and they (staff)	F9999			

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F9999	<p>Continued From page 33</p> <p>can't heal the one in my behind. "</p> <p>The Administrative Staff (Director of Nursing/E 2 and the Nurse Consultant/E 1) claimed R 12 has multiple pressure ulcers when she was re-admitted in the facility (from the hospital on 03-09-13). E 1 and E 2 were unable to identify which admission dates did R 12's pressure ulcers were initially noted.</p> <p>The most recent re- admission resident -data collection (re admission form) dated 03-09-13, under skin condition section showed the following instructions: Using the diagram provided, indicate all body marks such as old/recent scars (surgical and other), bruises, discolorations, abrasions, pressure ulcers or questionable markings. Indicate size depth (in cms (sic)), color and drainage.</p> <p>These instructions were not followed. The diagram showed a line drawn pointing at R 12's sacral and abdominal area, the left shin and a perma cath on the right chest. Comments reads: sacral wound Stage III, abdominal folds fungal infection, buttocks, left shin wound and right groin -hematoma.</p> <p>There was no other documentation found in R 12's clinical record or presented by the facility to show a thorough assessment was conducted until 03-11-13. There was no record/documentation the wounds or other skin alterations were measured including a description of each upon admission. These findings were discussed with the Administrative staff (E 2 and E 3) on 03-28-13 at 4:10 PM.</p> <p>On 03-28-13 at 1:30 PM, skin assessment was conducted with the Treatment Nurse (E 3). E 3 claimed R 12 has multiple pressure ulcers but all developed from the hospital. E 3 identified and describes the following pressure ulcers:</p>	F9999			

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F9999	<p>Continued From page 34</p> <p>(1) Coccyx - measured at 2.1 cm X 1.4 cm x 0.6 cm with 1.0 cm undermining at 12 o ' clock and 1.0 cm at 3 o ' clock. E 3 stated " with 100% yellow slough, this is a Stage III. "</p> <p>This pressure ulcer was incorrectly staged. The National Pressure Ulcer Advisory Panel (NPUAP) reads: Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown: Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined ...</p> <p>The re- admission (resident-data collection) form dated 03-09-13 showed no skin alteration on R 12 ' s coccyx.</p> <p>Based on the initial assessment conducted on 03-11-13 (the nurses progress notes skin alteration assessments) this pressure ulcer on R 12 ' s coccyx (initially identified as sacrum) progressed in size (from 2.4 cm X 1.7 cm X 0.9 cm, undermining at 3:00 1cm to 12:00 0.5 cm) and is now an unstageable pressure ulcer (from Stage III) measured at 2.1 cm X 1.4 cm x 0.6 cm with 1.0 cm undermining at 12 o ' clock and 1.0 cm at 3:00. .</p> <p>On 03-29-13 at 11:06 AM, E 1 stated " the Treatment Nurse called the wound doctor and upgraded the wound to Stage IV and also order a change in treatment. "</p> <p>(2) Right Hip - measured at 1.0 cm X 1.5 cm. E 3</p>	F9999			

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F9999	<p>Continued From page 35</p> <p>stated " it ' s covered with yellow slough, this is unstageable. " The re- admission (resident-data collection) form dated 03-09-13 showed no skin alteration on R 12 ' s right hip (upon admission).</p> <p>The initial assessment conducted on 03-09-13 (the nurses progress notes skin alteration assessments) this pressure ulcer on R 12's Right hip was identified as a Deep Tissue Injury and now identified as Unstageable pressure ulcer.</p> <p>R 12's pressure ulcer care plan for a deep tissue injury located on the right hip showed that this " problem starts on 03-18-13. " R 12 was re admitted in the facility on 03-09-13.</p> <p>E 1, E 2 and E 3 on several days of the survey were unable to present a comprehensive assessment to show the facility analyzes and address R 12's risk factors and co morbidities. Review of R 12 ' s Pressure ulcer Care Area Assessment (#16) was blank. The Minimum Data Set Coordinator (E 5) stated on 03-29-13 at 11:45 AM, E 5 confirmed the finding and stated " Yes, there's nothing in there (blank). They should have done one for her because she has a pressure ulcer. "</p> <p>R 12's coccyx care plan was not individualized and based on R 12's needs. The interventions were developed since 12-24-12. No revision was done and no repositioning plan developed. On 03-29-13 at 10:40 AM, E 1 and E 2 confirmed that they had not assessed R 12 for tissue tolerance test.</p> <p>E 1, E 2 and E 3 on several days of the survey were unable to present a comprehensive assessment to show the facility analyzes and address R 12's risk factors and co morbidities. Review of R 12 ' s Pressure ulcer Care Area</p>	F9999			

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F9999	<p>Continued From page 36</p> <p>Assessment (#16) was blank. The Minimum Data Set Coordinator (E 5) stated on 03-29-13 at 11:45 AM, E 5 confirmed the finding and stated " Yes, there's nothing in there (blank). They should have done one for her because she has a pressure ulcer. "</p> <p>R 12 ' s coccyx care plan was not individualized and base on R 12's needs. The interventions were developed since 12-24-12. No revision was done and no repositioning plan developed. On 03-29-13 at 10:40 AM, E 1 and E 2 confirmed they had not assessed R 12 for tissue tolerance test.</p> <p style="text-align: center;">(B)</p> <p>300.610a)</p> <p>300.1210b)</p> <p>300.1210d)6)</p> <p>300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and 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</p>	F9999			

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F9999	<p>Continued From page 37 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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All</p>	F9999			

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F9999	<p>Continued From page 38</p> <p>nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure, E6 the Certified Nurse Aide (CNA) used gait belt and bed was locked and secured when transferring R16 to prevent him from falling. this is for one sampled resident (R16) in the sample of 24.</p> <p>Findings include:</p> <p>The facility documented an incident on 3/28/13 at 7:15 am indicating R16 was found his 'buttocks on floor, back up against wheel chair foot rest.' It is noted in the incident report 'R16 stated he is non-compliant with safety practices, transferring himself from the bed to the wheel chair and he slipped.'</p>	F9999			

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F9999	<p>Continued From page 39</p> <p>On 3/28/13 at 10:45 am E6 assisted R16 from his wheel chair to toilet without using a gait belt. R16 has unsteady gait. After R16 was done using toilet E6 transferred him to wheel chair brought him to his bed side to transfer him to his bed. As E6 transferred R16 from wheel chair to bed, the bed slid and it stopped only because his room mate's bed blocked his bed from sliding farther that prevented him from falling. E6 stated she should have used gait belt and did not know why his bed was not locked.</p> <p>The investigation of R16's 3/28/13 7:15 am incident of falling did not rule out if the unlocked bed contributed for his falling.</p> <p>1. Based on record review and interview the facility failed to supervise and develop an individualize plan of care to address one of one supplemental sampled resident(R 26) who was known to sit up while sleeping These failures resulted in R 26 being found on the floor unresponsive and expired. Findings include: Review of nursing note dated 3/31/13 states at 3:00am, 2 nurse's aides came to nurse (E19) and reported R26 was found on the floor, vitals not detectable including respiration or blood pressure and pupils were dilated. There was blood noted from the right ear. Review of most recent quarterly Minimum Data Set (MDS) dated 3/12/13 shows R26 is 85 years old with diagnosis of hypertension, arthritis, Alzheimer's disease and depression. R26 has been a resident at the facility for 7.5 years. This</p>	F9999			

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F9999	<p>Continued From page 40</p> <p>MDS shows R26's cognition is severely impaired and requires extensive physical assist with activities of daily living. The MDS also states R26 has not had any falls which is incorrect as review of 2 incident reports dated 1/29/13 and 3/3/13 shows R26 was found on the floor next to her bed.</p> <p>Several direct care staff stated in interviews on 4/2/13 at 2:30pm (in person, E25 and E26, nurse's aides) and 4/3/13 (via phone, E19 at 9:30am, E2 at 1:50pm, nurses) R26 would sleep sitting up in bed without the aid if the head of the bed being raised. E25 and E26 stated that staff would try to lay R26 down but she would just sit up again. E25 and E26 also stated R26 could stand up on own and would attempt to do so from bed or chair occasionally. E25 stated R26 could walk a little but only with hands on assistance of one person and was at risk for falls. E2 stated on 4/2/13 at 2:00pm that R26 had fallen out of bed before.</p> <p>E2 (dir of nursing) stated on 4/2/13 at 2:50pm R26 did exhibit this behavior of sitting up while sleeping. At 3:20pm, E2 confirmed this behavior had not been care planned for and no assessments had been conducted for appropriate devices to be utilized in bed to prevent injury related to this behavior. E2 also stated no incident report or investigation had been completed to assist in analyzing the circumstances surrounding R26's incident and subsequent death.</p> <p>Interview with E22 (nurse's aide) stated on 4/3/13 at 1:50pm she was the person who discovered R26 on the floor at around 3:00am. E22 also said R26's alarm was on the bed but was not alarming when she (E22) walked into the room. E22 stated R26 was observed face down with her bottom in the air, lying on the floor mat. R26 had blood</p>	F9999			

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F9999	<p>Continued From page 41</p> <p>coming from her ear and a small amount dripped onto her neck. E22 notified the nurse immediately who called for the charge nurse on 1st floor to come assist. E22 stated the nurses were unable to obtain vital signs and determined R26 was unresponsive. E22 stated 4 staff assisted in rolling R26 onto a bed sheet and placed her back into bed. E22 and 2 other aides cleaned up R26. E22 also said that the staff would get R26 up last in the morning because she would fall forward in the chair because she was so sleepy. When sitting at a table, staff would place something soft in front of R26 so she would not hit her head on the table due to her jerky movements.</p> <p>E 23 (nurse) stated on 4/3/13 at 11:40am she was called and told R26 had passed away was asked to come to the 2nd floor to assist on 4/2/13 at around 3:00am. E23 said R26 was lying on her left side in a semi-fetal position and her color was pale, not normal color. E23 assessed R26 for vitals signs and found none. R26 was placed back in bed using a sheet. E23 said that afterwards, she spoke to E2 (director of nursing) by phone and was told to call the family and tell them R26 passed away. E23 stated she told the family R26 had been found unresponsive during rounds and did not tell the family R26 had been found on the floor.</p> <p>2. Based on observation, interview and record review, the facility failed to supervise: (1) R 21 with known history of verbal and physical aggression towards other residents, (2) R 14 who was identified with dementia with behavioral disturbance, (3) R21 who was identified roaming in and out of other resident's rooms and lying on the beds. This is for four sampled residents</p>	F9999			

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F9999	<p>Continued From page 42</p> <p>R8,R14,R20 and R21 and one supplemental sampled resident R25 in the sample of 24 This resulted in multiple physical altercations involving R21, R8, R14 and R25 and R14 sustaining dark blue discoloration and swelling of her 4th and 5th fingers.</p> <p>Review of final report of resident to resident altercation dated 2/1/13 shows R21 (age 89) and R8 (age 87) were sitting in front of the nursing station when R21 propelled herself over to R8 and hit R8 on the hand unexpectedly and without provocation. R8 responded by slapping R21 on the face. The facility concluded both residents are confused and unable to effectively communicate with each other. This incident is noted on R21's care plan and states it was witnessed by staff. A second care plan dated 3/7/13 states R21 had an unwitnessed episode of hitting another resident that was reported by a peer. It is unclear if there was a second incident involving R21 or if this was inaccurately care planned.</p> <p>On 3/26/13 in the 2nd floor dining room at 12:20pm, R21 displayed verbal and physical aggression toward a surveyor after R21 observed the surveyor in a conversation with another resident. R21 picked up a utensil from the table and attempted to approach the surveyor while in her wheelchair but was unable to do so because the wheelchair was locked. Several minutes later, R21 became very agitated and pushed the items off the table and onto the floor, including a cup of coffee.</p> <p>Review of Behavior section of most recent full Minimum Data Set dated 12/13/13 shows assessment of R21 ' s behavioral symptoms :</p> <ul style="list-style-type: none"> Put R21 at significant risk for physical injury. Significantly interfere with R21 ' s care. Significantly interfere with R21 ' s 	F9999			

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F9999	<p>Continued From page 43</p> <p>participation in activities or social interactions. R21 ' s behavioral symptoms have an impact on others by:</p> <p>Putting others at significant risk for physical injury.</p> <p>Significantly intruding on the privacy or activity of others and disrupting the care or living environment.</p> <p>The results of this Minimum Data Set behavioral assessment indicates R21 is at risk for abuse.</p> <p>Review of incident summary dated 3/6/13 states that R14 is 70 years old with impaired cognition including impaired memory, comprehension and problem solving skills. R14 ' s medical history includes dementia with behavioral disturbance and anxiety. R 14 demonstrates impulsive behavior and hoards items. On 3/5/13 at 10:00am, R14 was noted to have dark blue discoloration and swelling of her 4th and 5th fingers. R14 was seen by the physician who ordered an Xray of the right hand. The report stated that the bruising and swelling was most likely due to impulsive behavior and accidentally bumping self on surface given that she exhibits anxiety tremors and is on Coumadin therapy. The summary concludes by stating R14 " Remains at risk for skin alteration due to risk factors and co morbidities. "</p> <p>Review of a prior incident report involving R14 and dated 11/1/12 shows on 11/1/13 at 7:50am, E19 (nurse) heard R14 screaming and asking for help. E19 checked immediately. E19 saw R25 and R14 fighting. R14 told E19 that R25 'hit me in the head and it hurts. He doesn't like me. Let him stay away from me.' After the incident, R14 complained of headache and noted pain at 8/10. Review of the Final Report submitted to IDPH states there were no witnesses to this altercation</p>	F9999			

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F9999	<p>Continued From page 44</p> <p>and concludes the incident is related to both parties being confused and not being able to effectively communicate with one another. This is in contradiction to what the nurse documented on the Incident report stating she witnessed the 2 fighting. Also, review of R25's incident report shows R25 concedes he did strike R14 because she was taking something from him. In the summary portion of R14's incident report it states staff are to closely monitor and limit interaction between these two residents. However, this report states that during this investigation period, (on 11/2/12, 1 day after physical altercation) "it was noted that (R25) threw a cup of water on (R14) the day after the initial incident. It was noted (R14) continues to repeat the statement "he hit me" frequently throughout the day and evening, even though (R25) was not near her or even in the same area."</p> <p>Review of care plan dated 2/14/13 states that R14 " Has observed and perceived conflict with peers. (R14) perceives conflict with one particular male peer. Episodes of alleged physical altercation. Unwitnessed/not observed. No injuries noted. Verbal conflict observed and ongoing. (R14) is very persistent on this conflict. " On 3/28/13 at 10:40am, E2 confirmed abuse was not ruled out as a possible factor into the 3/16/13 incident to R14 and that no further interventions have been put into place to assist R14 in feeling safe.</p> <p>During the resident group meeting on 3/27/13 at 10:30am, 6 of the 8 residents in attendance voiced complaints of R20 roaming in and out of their rooms and responding with verbal aggression when asked to leave the rooms she does not belong in. Two of the residents stated they were concerned that R20 may get hurt by</p>	F9999			

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F9999	Continued From page 45 other residents due to wandering in and out of resident rooms and lying on the beds. Other residents are irritated by R20 's behaviors. These residents stated staff had moved R20 to the end of the hall, making it more difficult for staff to watch her. Review of most recent care plan dated 3/27/13, 3rd day of survey, (no prior care plan addressed this issue) states R20 is exhibiting a new behavior of wandering into other resident rooms and is in an adjustment period after a room change. The CAA dated 12/11/12 (care area assessment) states R20 has severely impaired cognitive deficits. R20 was moved from room 128 to room 123 (which is further away from the nursing station and at the end of the hall.) E2 (director of nursing) stated on 3/28/13 at 10:40am that she is unaware of the facility performing assessments to assist in identifying residents at risk for abusive behavior. E2 stated she would talk to the social service department to see if they did such assessments. None was provided by end of survey on 3/28/13. (B)	F9999			