STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HELIA HEALTHCARE OF BENTON	**1310 MARK FRANKLIN LOUIS STREET BENTON, IL 62812**

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F 497	Continued From page 29 that she does not know how many hours of inservice training the Certified Nurse Aides (CNA) have who work at the facility. E3 also stated that at one time she did keep track of the hours but does not keep track now. Review of the facility employee inservice education information documents that the most recent staff abuse inservice is dated 07-26-13 and documents that the facility reviewed the full abuse policy and procedure. Of the 25 Certified Nurse Aides who were hired before the date of the in-service, 18 (E4, E5, E9-E26) did not attended this inservice. E4, Certified Nurses Aide, and E5, Certified Nurses Aide, (who had some involvement in abuse incident) did not receive the abuse policy and procedure training according to the attached inservice. This training material included appropriate interventions to deal with aggressive and or catastrophic reactions of residents. E4 stated during an interview on 09-26-13 at 12:50 pm that she did miss the last abuse inservice about two months ago. E5 stated during an interview on 09-26-13 at 2:55pm that she had training while in school and that at one time at this facility they had abuse inservice every other pay day but it would be good to offer training during midnight shift. On 09-24-13, the facility indicated an in-house census of 70 residents on the Facility Data Sheet.	F 497		
F9999	FINAL OBSERVATIONS STATEMENT OF LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 30 300.610a)4)B) 300.6104)E) 300.1210b) 300.1210c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling; E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that	F9999		

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F9999	Continued From page 31 the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury; 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on observation, interviews, and record review, the facility staff failed to prevent one resident (R3) from receiving serious physical injury due to staff (E6) raising R3's leg to eye level and with enough force to cause the resident who was seated in a wheelchair with a seatbelt on to fall backwards, hit head on the floor, and receive an Intracranial Hemorrhage with Subarachnoid Hemorrhage which resulted in	F9999		

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death for 1 of 3 residents (R3) reviewed for falls in the sample of 3.

Findings include:

R3 was an 88 year old female that resided in the facility since July 31, 2007 with diagnoses that include Muscle Weakness, Gait Abnormality, Abnormal Posture, Persistent Mental Disorder, Alzheimer's, Senile Dementia - Uncomplicated, according to the Resident Admission Record dated 07-31-07.

According to the most recent quarterly Minimum Data Set (MDS) dated July 22, 2013, R3 has physical behavioral symptoms of hitting, kicking, scratching, grabbing, threatening, screaming, and cursing others. R3's quarterly MDS dated July 22, 2013 documents that she had long and short term memory issues.

R3's Care Plan dated July 25, 2013, has a Problem listed as R3 exhibits non-compliant behavior by refusing her medications and treatments with an approach listed as "reapproach when refusing care and treatments; and for residents safety use 2 staff when doing care" and another Problem listed as R3 has difficulty with communicating needs and following simple commands at times due to cognitive decline with an approach listed "observe closely and anticipate needs as needed".

R3's wheelchair was observed on 09-24-13 at 10:15 am to be shorter than a normal sized wheelchair with a self releasing seat belt and a seat belt alarm hanging on the back of the chair. According to E3, Certified Nurse Aide Supervisor, on 09-25-13 at 2:12 pm, the wheelchair, weighs

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40 lbs. Measurements of R3's chair on 09-27-13 documents the chair was 15 inches from the floor to the seat (Height) and 15 inches from the seat edges (width). Also observed during this time was the wheel chair brakes on the right side of the chair in the locked position allows the right chair wheel to move freely and the brake on the left side of the wheel chair in the locked position does not allow the wheel to move. According to the Vital Sign and Weight Record R3 weighed 156 pounds on September 20, 2013 and according to the Minimum Data Sets (MDS) dated April 22, 2013, R3 is 5 feet 2 inches tall.

The Nurses Notes dated September 21, 2013 at 4:45 A.M. documents E6 (Licensed Practical Nurse) lifted R3's foot up. The wheelchair with the resident in it went backwards. R3 did not appear to hit any body parts. E6 undid quick release belt allowing R3 to slide out of the wheelchair with assistance of E4 and E5 (Certified Nurses Aides).

An Incident Report dated September 21, 2013 at 4:45 A.M. completed by E6 states "I bend down lifted foot up causing w/c (wheel chair) to tip backwards with resident, a seat with self release belt intact", and lists R3's condition before the incident as aggressive and strikes at staff for all activities of daily living.

E6 was interviewed over the phone on September 25, 2013 at 11:05 A.M., and E6 stated that "as I raised R3's leg by the pant leg, R3 slapped me. I stepped back and I lifted her left leg placing my hand on the back of her heel and the next thing I knew she was on the floor, the wheel chair tipping over backwards."

An undated statement with the time given as 4:15

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A.M. written by E6 includes the following. "I bent over to remove excess tape and R3 struck me on the side of my face knocking my glasses askew. I backed up half a step and raised foot again, the next thing I knew R3's wheelchair was tipped backwards and R3 was lying still in seat position with self release restraint in place."

E4, Certified Nurses Aide, wrote a statement dated 09-23-13 that states on Saturday, September 21, 2013 at approximately 4:30 am, E4 put R3 in her wheel chair and secured her safety belt and locked the wheelchair. E6, Licensed Practical Nurse, tried to look at R3's dressing on her toes and R3 started kicking at him. E6 was observed to grab R3's leg in a rough and abrupt manner, jerk her leg up to her eye level, flipping R3 backwards in her wheel chair and causing R3's head to hit the floor with a sound "like a baseball bat hitting a ball of a grand slam".

Also, E4 wrote a seven page letter addressed to E1, Administrator and left it for E1 to read on 09-23-13. This letter states that E6, Licensed Practical Nurse, was in a "very bad mood" during his midnight shift (10 PM to 6 AM) on 09-21-13. E4 describes in this letter that E6's rough and abrupt actions caused R3 to fall backwards onto the floor in her wheel chair. Also, E4 wrote that E4 spoke with E3, Certified Nurse Aide Supervisor,several times and was told to write in her statement everything before and after the incident of 09-21-13. E4 stated she also spoke to E2, Director of Nurses, who told E4 to "only write what happened in the room and I shouldn't (should not) use words in the report like her leg was lifted rough or abruptly" and E4 should report only "that he lifted her leg and the chair tipped

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F9999	Continued From page 35 over". During a phone interview on September 25, 2013 at 2:40 P.M., E4 stated the following. E4 stated E6 reached for R3's foot and jerked R3's leg so high R3's left leg came up to R3's face, eye level and the wheelchair tipped over, and E6 is "too rough with the residents". E4 also stated she reported to E7 (Licensed Practical Nurse who was working on the other hall) shortly before E4 left the facility at the end of the shift at approximately 6:00 A.M. the way R3's leg was lifted. E4 stated E2 (Director of Nurses) called E4 between 7:30 A.M. and 9:30 A.M. and E4 told E2 at that time how E6 grabbed R3's leg and the leg was above R3's head when the wheelchair tipped backwards. E4 said E2 told E4 the situation would be investigated and that E2 would contact E1 (Administrator). E4 stated she sent a text message to E3 (Certified Nurses Aide Supervisor) after E4 talked with E2 around 10:00 A.M. and explained that E6 grabbed R3's leg and lifted it up to R3's eye level hard causing the chair to flip. During an interview on September 25, 2013 at 1:45 P.M., E3 stated E3 had received a text from E9 saying R3 had an accident. E3 called the facility and talked with E9 and was told E 10 (Certified Nurses Aide) gave E4 a ride home on September 21, 2013 and E4 was upset about what happened in R3's room. E3 called E4 at home on September 21 at 7:43 A.M. and E4 reported E6 lifted E3's legs up to high and the wheelchair went back and R3 fell backwards. On 10-03-13 at 2:10 pm E3 was interviewed by phone and stated that E4 told her that E6 "jerked R3's leg up roughly".	F9999		

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During an interview on September 27, 2013 at 12:20 P.M., E7 stated that E4 told E7 later the morning of 09-21-13 that "there was more that happened in R3's room" and E7 said she told E4 "you have to report and tell the truth". E4 called E7 Sunday morning around 8:30 A.M., and said to E7 "E6 was rough and abrupt in E4's opinion but never used the word abuse."

E2 stated on 09-25-13 at 10:15 am that she was notified that R3 had fallen and was sent to the emergency room at approximately 4:40 am on 09-21-13 but she did not start an investigation of the incident until 09-23-13.

E1 was interviewed at 10:10 am on 09-25-13 and stated that he was notified on 09-21-13 sometime in the morning (exact time unknown) that R3 had fallen but did not have any idea that E4 thought it was because of a rough act by E6. E1 verified that they did not start an investigation until 09-23-13 at 8:15 am.

A 09-21-13 Radiology Report from a Computer Topography (CT) of R3's head documents the impression as "Significant posterior fossa acute Intracranial hemorrhage with Subarachnoid hemorrhage extending into the pons with Intraventricular hemorrhage." This was obtained after R3 went to the emergency room the morning of 09-21-13 according to Z3 and Z4, Emergency Room Registered Nurses during an interview on 09-26-13 at 1:20 pm. Z3 confirmed that R3 expired on 09-25-13.

The History & Physical for R3's admission to the hospital on 09-21-13 documents the chief complaint as "Unresponsiveness". The plan given was to provide comfort and no aggressive

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measures due to R3's condition and poor prognosis.

Z1, Physician for R3 stated during a telephone interview on 10-02-13 at 7:35 am that "R3 has been his patient for many years and R3's cognitive status has declined in the last few years to the point she does not recognize anyone." Z1 described R3 as been non-compliant, hitting and being physically aggressive. When asked about Z1's examinations of R3, Z1 stated that "he would try to exam her but she would hit, because she always hit and "I would leave her alone, just back off as I should have. As staff should have." Z1 stated, "(R3) is the kind of resident that things like this happen to because of her behaviors. When she was having behaviors with care, staff should have backed off. That is what she wanted." Z1 also stated that usually a fall causes the hemorrhage and the hemorrhage causes the death but that cannot be proven until the autopsy report is received.

Z2, Coroner, stated in an interview on 10-02-13 at 11:05am that R3's Death Certificate is "Pending Investigation". Z2 stated that it will be a few weeks until the pathologist report on the brain autopsy is received.

The facility policy titled "Abuse, Prevention and Prohibition Of" with a revision date of July 2011, documents in this policy under Screening "The facility will not knowingly employ individuals who have been found guilty of abusing, neglecting or mistreating residents or misappropriating their properties. A person at a supervisory level will interview potential employees. All employees will have criminal background checks, state and federal required checks, employment reference

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checks (previous and current), and license/certification confirmation.. The facility will make reasonable efforts to uncover information about any past criminal prosecutions."

Review of the employee file for E6, Licensed Practical Nurse, documents that E6 was hired on 05-11-12 and did not have a background check completed and his facility Telephone Reference Check Form only had his name on it with no other information completed. The Illinois Department of Financial and Professional Regulations (IDFPR) license look up information was not found. E1, Administrator stated during an interview on 09-16-13 at 6:50 PM that the IDFPR license look up information was found. The information for E6 documents that E6 had been disciplined with a suspension from 03-05-1993 to 06-04-1993 for "Alleged mistreatment residents" and Probation from 06-05-1993 to 06-04-1995 for "Alleged mistreatment residents". E1 and E2, Director of Nurses stated they did not know of this disciplinary action on E6's Licensed Practical Nurse license.

2. The facility policy titled "Abuse, Prevention and Prohibition Of" with a revision date of July 2011, documents in this policy under Training: "Facility staff shall be trained on the abuse prohibition program during orientation, annually, and ongoing during educational sessions.....Additional In-services shall include: Appropriate interventions to deal with aggressive and or catastrophic reactions of residents. (Catastrophic reactions are defined as reactions or mood changes of a resident in response to what may seem to be minimal stimuli."

Review of the facility employee inservice

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education information documents that the most recent staff abuse inservice is dated 07-26-13 and documents that the facility reviewed the full abuse policy and procedure. Of the 25 Certified Nurse Aides who were hired before the date of the in-service, 18 (E4, E5, E9-E26) did not attended this inservice. Of the 9 Registered Nurses and Licensed Practical Nurses that were employees before the date of the in-service, 6 nurses (E6, E7, E27-E30) did not attend the inservice. E4, Certified Nurses Aide, E5, Certified Nurses Aide, , E6, Licensed Practical Nurse, and E7, Licensed Practical Nurse (all who had some involvement in this incident) did not receive the abuse policy and procedure training according to the attached inservice. This training material included appropriate interventions to deal with aggressive and or catastrophic reactions of residents.

E4 stated during an interview on 09-26-13 at 12:50 pm that she did miss the last abuse inservice about two months ago. E5 stated during an interview on 09-26-13 at 2:55pm that she had training while in school and that at one time at this facility they had abuse inservice every other pay day but it would be good to offer training during midnight shift.

3. The facility policy titled "Abuse, Prevention and Prohibition of" with a revision date of July 2011, documents in this policy under Identification: "Upon report of such abnormalities of suspicious injuries (black eyes, rope marks, cigarette burns) the Director of Nursing is responsible for their evaluation and assessment....An abuse investigation may also be conducted based on the investigation findings."

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F9999	Continued From page 40 (A) 300.661 300.690a) 300.690b) 300.690c) 300.695b)1) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	F9999		

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F9999	Continued From page 41 c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor; Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of	F9999		

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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 42 abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on interviews, observations and record review, the facility failed to immediately start an abuse investigation after administrative staff received a report of staff raising a resident's (R3) leg up high and with enough force to cause the resident who was seated in a wheelchair with a seatbelt on to fall backwards, hit head on the floor, and receive an Intracranial Hemorrhage with Subarachnoid Hemorrhage which resulted in the resident death. The facility staff failed to immediately report the incident of alleged physical abuse to the Administrator. The facility staff failed to notify law enforcement and the state agency regarding the alleged physical abuse. The facility also failed to thoroughly screen potential employees, train current employees, and failed to protect all residents by allowing the staff	F9999		

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	146088	A. BUILDING _____ B. WING _____	C 10/04/2013

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involved to continue to work two more midnight shifts.

These failures resulted in 70 in-house residents being at risk of potential abuse.

The findings include:

On 09-24-13, the facility indicated an in-house census of 70 residents on the Facility Data Sheet.

E4, Certified Nurses Aide, wrote a statement dated 09-23-13 that states on Saturday, September 21, 2013 at approximately 4:30 am, E4 put R3 in her wheel chair and secured her safety belt and locked the wheelchair. E6, Licensed Practical Nurse, tried to look at R3's dressing on her toes and R3 started kicking at him. E6 was observed to grab R3's leg in a rough and abrupt manner, jerk her leg up to her eye level, flipping R3 backwards in her wheel chair and causing R3's head to hit the floor with a sound "like a baseball bat hitting a ball of a grand slam".

Also, E4 wrote a seven page letter addressed to E1, Administrator and left it for E1 to read on 09-23-13. This letter states that E6, Licensed Practical Nurse, was in a "very bad mood" during his midnight shift (10 PM to 6 AM) on 09-21-13. E4 describes in this letter that E6's rough and abrupt actions caused R3 to fall backwards onto the floor in her wheel chair. Also, E4 wrote that E4 spoke with E3, Certified Nurse Aide Supervisor,several times and was told to write in her statement everything before and after the incident of 09-21-13. E4 stated she also spoke to E2, Director of Nurses, who told E4 to "only write

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what happened in the room and I shouldn't (should not) use words in the report like her leg was lifted rough or abruptly" and E4 should report only "that he lifted her leg and the chair tipped over".

E4 was interviewed by phone on 09-25-13 at 2:40 PM. During this interview, E4 stated that "E6 reached for R3's foot and jerked her leg up high. R3's leg came up to R3's eye level and the chair tipped over." E4 said "The noise was so loud, it sounded like a bat hitting something." When asked when E2, Director of Nurses, was notified, E4 stated that "E6 called E2 after the incident happened." E4 also stated that "E7 called E4 sometime between 7:30 am and 9:30 am. E4 told E7 during this phone call that E6 grabbed R3's leg and it was pulled above her head causing the wheel chair to tip backwards." E4 stated "around 10am on 09-21-13, E4 talked to E2 and told her what happened." E4 stated during this interview that "E2 told her E2 would investigate the incident and E2 would also contact E1, Administrator. E2 stated she also sent a text message to E3 after the conversation with E2 and told her what happened."

E7 was interviewed by phone on 09-27-13 at 12:20pm and stated that later the morning of 09-21-13, E4 did tell her "I need to tell you something, there was more that happened in that room. There is more to it." E7 stated that she told E4, "You have to report and tell the truth."

E2 stated on 09-25-13 at 10:15 am that she was notified that R3 had fallen and was sent to the emergency room at approximately 4:40 am on 09-21-13 but she did not start an investigation of the incident until 09-23-13.

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E2, Director of Nurses, wrote a statement dated 09-21-13 at 4:40 am that she received a call from E6, Licensed Practical Nurse, and stated that he was getting ready to send R3 to the hospital due to a possible head injury. E2 stated that E6 leaned down to secure the bandage to R3's foot and had raised her leg up to observe the dressing. R3 was agitated and was kicking at him. E6 stated that the next thing E6 knew the resident was tipping backwards in the chair. On 09-26-13 at 11:30 am, E2 stated that no one mentioned rough or unusual treatment to her so she did not think she needed to start an abuse investigation. E2 stated that an abuse investigation was started on 09-23-13 when she read a statement by E4 stating that E6 was rough with R3. E2 stated she did not think this incident was suspicious or unusual.

E1 was interviewed at 10:10 am on 09-25-13 and stated that he was notified on 09-21-13 sometime in the morning (exact time unknown) that R3 had fallen but did not have any idea that E4 thought it was because of a rough act by E6. E1 verified that they did not start an investigation until 09-23-13 at 8:15 am.

Review of the employee file for E6, Licensed Practical Nurse, documents that E6 was hired on 05-11-12 and did not have a background check completed and his facility Telephone Reference Check Form only had his name on it with no other information completed. The Illinois Department of Financial and Professional Regulations (IDFPR) license look up information was not found. E1, Administrator stated during an interview on 09-16-13 at 6:50 PM that the IDFPR license look up information was found. The

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information for E6 documents that E6 had been disciplined with a suspension from 03-05-1993 to 06-04-1993 for "Alleged mistreatment residents" and Probation from 06-05-1993 to 06-04-1995 for "Alleged mistreatment residents". E1 and E2, Director of Nurses stated they did not know of this disciplinary action on E6's Licensed Practical Nurse license.

Review of the facility employee inservice educations information documents that the most recent staff abuse inservice is dated 07-26-13 and documents that the facility reviewed the full abuse policy and procedure . Of the 25 Certified Nurse Aides who were hired before the date of this inservice, 18 (E4,E5, E9 - E26) did not attended this inservice. Of the 9 Registered Nurses and Licensed Practical Nurses that were employees before the date of the inservice, 6 nurses (E6, E7, E27-E30) did not attend the inservice. E4, Certified Nurses Aide ,E5, Certified Nurses Aide, E6, Licensed Practical Nurse, and E7, Licensed Practical Nurse (all who had some involvement in this incident) did not receive the abuse policy and procedure training according to the attached inservice. This training material included appropriate interventions to deal with aggressive and or catastrophic reactions of residents. E4 stated during an interview on 09-26-13 at 12:50 pm that she did miss the last abuse inservice about two months ago. E5 stated during an interview on 09-26-13 at 2:55pm that she had training while in school and that at one time at this facility they had abuse inservice every other pay day but it would be good to offer training during midnight shift.

E2 stated on 09-25-13 at 10:15 am that E6 worked midnights on 09-21-13 and 09-22-13, the

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F9999	Continued From page 47 two days following the incident. The facility Nursing Schedule for September 8th - 21st, 2013 and September 22nd - October 5, 2013, documents that E6 worked midnights on 09-21-13 and 09-22-13 after R3's fall and E4's allegations against E6 were made known. Review of the Regional Illinois Department of Public Health incident and accident file for this facility did not indicate that an incident report or a notice of an allegation of abuse by E6 to R3 had been initiated. On 09-25-13 at 1:15 PM, E1 stated that an incident report was completed and faxed on 09-21-13 at 12:16 PM. E1 then stated that the fax did not go through and produced a "Fax Error Report" for this incident dated 09-21-13 at 12:16 PM. Also, E1 stated during a 09-26-13 at 7:15 pm interview that he did not re-send this incident report nor did they send a notification of allegation of abuse involving R3's fall on 09-21-13. E1 was observed sending by fax the notification of the 09-21-13 incident and the notification of the abuse investigation concerning this incident at 7:25pm on 09-26-13 to Public Health. E1 also stated during this interview that law enforcement was not notified. The final facility abuse investigation of this 09-21-13 abuse allegation involving R3 has not been received as of 10-02-13. (A)	F9999		