

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER MORTON TERRACE H & R CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 191 EAST QUEENWOOD ROAD MORTON, IL 61550
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240d) 300.3240f)</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. 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.</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</p>	S9999		
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Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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>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. (Section 2-107 of the Act)</p> <p>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)</p> <p>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)</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)</p> <p>These Regulations were not met as evidenced</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>by:</p> <p>Based on record review and interview, the facility failed to ensure resident protection from verbally abusive threats of physical harm and from actual physical abuse, for two of 20 residents (R2, R12) reviewed for abuse, in a sample of 20 and for one resident (R22) on the supplemental sample. Based on record review and interview, the facility failed to ensure that actual physical abuse, verbally abusive threats of physical harm, and sexual abuse were reported immediately to the Administrator, investigated to prevent further potential abuse and reported to the State agency for three of 20 residents (R2, R7, R12) reviewed for abuse, in a sample of 20 and for two residents (R22, R33) on the supplemental sample. Based on record review and interview, the facility failed to follow operational policies and procedures regarding the identification, reporting, investigation and prevention of physical, verbal and sexual abuse for three of 20 residents (R2, R7, R12) reviewed for abuse, in a sample of 20 and for two residents (R22, R33) on the supplemental sample. Based interview and record review, the facility failed to effectively manage operations to maintain the safety of each resident and to maintain each resident's highest practical physical, mental, and psychosocial well-being for three of 20 residents (R2, R7, R12) reviewed for abuse. E1 (Administrator) and E2 (Director of Nursing) failed to ensure the facility policy on Abuse Prevention was followed. This resulted in Administration's failure to identify, report and investigate R2, R7, and R12's abusive behaviors towards residents and the Administration's failure to ensure the physical, mental and psycho-social well-being of those residents affected by abuse. This failure has the</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>potential to effect all 97 residents in the facility. These failures resulted in R2 making repeated verbal threats to kill R12, while they resided in the same resident room over a prolonged period of time, R2 threatening to kill R20, and R2 physically harming R22 and an unidentified resident. Additionally, R12 was allowed to make repeated verbal threats to multiple residents and make repeated sexual advances towards female residents, including displaying sexually inappropriate behavior. This failure has the potential to affect all 97 residents in the facility.</p> <p>Findings include:</p> <p>The Facility policy, titled "Abuse Prevention", documents "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by.....establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; immediately protecting resident involved in identified reports of possible abuse.....This facility is committed to protecting our residents from abuse by anyone including, but not limited to facility staff, other residents,</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>consultants, volunteer, staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals." The "Abuse Prevention" policy identifies physical abuse as "the infliction of injury on a resident that occurs other than by accidental means....hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." Additionally, the "Abuse Prevention" policy identifies mental abuse as "harassment, threats of punishment or deprivation" and verbal abuse as "threats of harm, saying things to frighten a resident."</p> <p>1. A Physician's Order sheet, dated 6/01/14, documents R2 was admitted to the facility on 12/31/14 with the diagnosis of Dementia.</p> <p>Nursing notes dated 2/15/14, document R2 started to develop verbal and physical aggression towards staff. On 2/18/14, nursing notes document R2 as "yelling at staff and other residents" and that (R2) "owns the place and everyone will do as (R2) says, or else." On 2/26/14 and 2/27/14, nursing notes document R2 was "refusing" to let (R2's) new roommate sleep in R2's room. Nursing notes dated 2/27/14, document R2 "does threaten other (patients) and has to be redirected numerous times a day."</p> <p>Nursing notes dated 3/09/14, at 11:50 p.m., document "This writer and CNA (Certified Nursing Assistant) heard a commotion in resident's room. After entering room, noted resident (R2) standing over roommate (R12) with walker up in the air and stated to roommate 'I'll kill you.' This writer and CNA escorted resident in hallway. Resident attempted to hit CNA, when CNA moved out of resident's way, resident lost balance falling to the floor, hitting (R2) head.....laceration on occipital</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>area of head." Nursing notes indicate R2 was transported to the Emergency Room and returned to the facility on 3/10/14 at 3:17 a.m. Documentation of a "Room Timeline" on R2, indicates R2 was returned to the facility on 3/10/14 and placed in the same room with R12.</p> <p>R12's nursing note, dated 3/15/14 at 10:30 a.m., documents, "(R12) came out of bathroom and threw water on roommate (R2) as (R2) was laying in bed. R12 became agitated because roommate came after (R12)." Nursing notes dated 3/15/14 at 1:00 p.m., document R2 as "not getting along with roommate today, keeping separated as much as possible."</p> <p>Nursing notes dated 4/27/14 at 8:00 a.m., document R2 "came out of room with a piece of roommate's bed frame, raising it up and threatening to hit anyone in (R2's) way. Opened up a door where a resident (R20) was sitting and watching TV (television) and went over to (R20) with this piece of bed frame, raised above (R2's) head and threatening to kill (R20). Staff came in between them and (R2) threatened to hit staff as well. (R2) left room walking down hall, grabbing metal chairs, books, whatever (R2) could reach. Grabbed another resident (R22) by the hair, almost used (R2's) fist to hit (R22) in the head. Nurse stopped the blow and (R2) hit nurse in the jaw. 911 called.....transportation to ER (emergency room) per stretcher." Nursing notes further indicate R2 was returned to the facility at 2:05 p.m. On 4/28/14, R2's Plan of Care was updated, identifying R2 as "becoming easily agitated causing (R2) to act out in the following ways: physical altercations, destruction of property" and instructs staff to provide 1:1 as needed, as an intervention.</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>Nursing notes dated 4/28/14 at 1:35 a.m., document "(R2's) roommate put on call light. (R2) tore down privacy curtains from wall and covered up with them. Roommate stated, 'I don't want to be in the same room with this crazy man.' Roommate moved to another room." Documentation of a "Room Timeline" on R2, indicates R2 remained in the same room with R12 until 5/23/14.</p> <p>On 6/18/14 at 9:25 a.m., E18 (Alzheimer's Unit Coordinator) stated R12 was moved on 4/28/14, but the move was only temporary and for that night.</p> <p>Nursing notes dated 5/04/14, document "(R2) began yelling at roommate (R12) and threatening to 'kill him' and take his walker. Staff intervened. (R2) then went into another resident room after (R2) had calmed down and began fighting with that resident (unknown resident). (R2) hit that resident and scratched his face. Staff separated the two residents and took (R2) to the Dining Room to eat breakfast. (Doctor) called for ok to send to (hospital) for (evaluation due to) behaviors." Subsequent nursing notes, on 5/04/14, indicate R2 was admitted to the Psychiatric Unit for treatment.</p> <p>Nursing notes dated 5/23/14, indicate R2 returned to the facility and the "Room Timeline" indicates R2 was placed in a different room, but with R12 as a roommate.</p> <p>On 6/18/14 at 10:15 a.m., E1 (Administrator) stated (E1) was the Abuse Coordinator and was unaware of either occurrence in which R2 threatened to "kill" R12 and was unaware that R12 had asked to be moved to another room, away from R2. E1 stated, had (E1) been aware</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>of the conflict between R2 and R12, they would not have been "left in the same room after the first incident." E1 denied knowledge of the abusive behavior of R2 on 3/09/14, 4/27/14 and 5/04/14 or knowledge of R12's abusive behavior towards R2 on 3/15/14, indicating those occurrences should have been investigated to ensure all residents on the Alzheimer's Unit's were protected from abuse.</p> <p>On 6/18/14 at 9:52 a.m., E2 (Director of Nursing) stated nursing staff reported R2's physical abuse on 4/27/14 directly to (E2) and then (E2) reported the incident to E1. E2 stated it was assumed that R12's request to change rooms on 4/28/14 would be a permanent change, considering the seriousness of the threats.</p> <p>2. A Physician's Order Sheet dated 6/01/14, documents R12 is 61 years old, with the diagnosis of Dementia with Psychosis and residing on the secured Alzheimer's Unit. A Minimum Data Set dated 3/07/14, documents R12 as totally independent with ambulation. A Plan of Care dated 11/26/13, identifies R12 as "expressing increased level of depression and seeking female companionship." A Plan of Care dated 3/05/14, documents R12 as having "behavioral symptoms not directed towards others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)."</p> <p>A Nursing Note, dated 3/18/14, documents R12 as "agitated multiple times this shift, yelling and cursing at staff and residents.....Resident has been in the other resident rooms, taking things that don't belong to him. A female's underwear</p>	S9999		
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S9999	<p>Continued From page 8 (found) under (R12's) pillow."</p> <p>A Nursing Note dated 5/22/14, documents R12 "has been taking things from other rooms and becomes very combative with staff and other (residents)." A Nursing Note dated 5/23/14, documents R12 "increasing with agitation, yelling at staff and residents, going in and out of resident rooms, while yelling at residents." A Nursing Note dated 5/29/14, documents "(R12) is yelling and cursing at staff (and) other residents. Throwing things." Nursing Notes dated 5/30/14, document R12 "down in Dining Room, yelling at staff and (residents) again. Swinging cane and yelling in staff and (resident) faces to intimidate them."</p> <p>Nursing Notes, dated 6/2/14 at 7:43 p.m., document R12 "sitting by nurses station, cussing and threatening other residents, continually telling residents to 'shut the f*ck up', calling them 'stupid' and 'idiots' and demanding they go to bed. Told one resident she was a 'crackhead prostitute with a stink a** p*ssy'. Told a male resident he'd smash his head and pointed his finger at him like a gun and made a repeated popping sound. Residents were visibly uncomfortable and anxious." At 8:37 p.m., the nurse documented "(R12) sitting by nurses station conversing with C.N.A. (Certified Nursing Assistant). Coerced female resident to sit in chair next to (R12). Made repeated attempts to hold resident's hand and rub her arm. Redirected by this nurse, complied."</p> <p>Nursing Notes, dated 6/03/14, document R12 "was in the dining room and started calling another (resident) a 'stupid f*cking b*tch'. This nurse asked (R12) to please stop calling people names. He then started cussing at this nurse. (R12) was asked to stop cussing many times</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>then got up and left the dining room."</p> <p>Nursing Notes, dated 6/06/14 at 9:00 a.m., document "(R12) was in dining room, making sexual gestures at another female (resident). When staff informed (R12) that is inappropriate for (R12) to make those gestures towards a lady, (R12) became aggressive, began throwing cups, (R12's) walker, plates and food....Staff cleaned the table and then removed the female (resident)."</p> <p>Nursing Notes, dated 6/09/14, document R12 "has been found in other rooms, taking things..... (R12) was caught trying to kiss other female residents, putting (R12's) hands on them, rubbing their backs, ears and heads. Explained to (R12) that was inappropriate."</p> <p>Nursing Notes, dated 6/11/14 at 10:30 a.m., document (R12) "sitting in hallway on B-Wing with another female (resident) and (continues) to keep putting (R12's) hands on the (resident) and rubbing her shoulder, calling her (R12's) 'girlfriend'." At 12:30 p.m., Nursing Notes document, "(R12) walking out of dining room and a female (resident) was walking in when (R12) grabbed the female resident's buttocks. The female resident turned around and hit (R12) with a doll." At 3:30 p.m., Nursing Notes document "New order received for Megace 400 mg (milligrams) one (by mouth daily, diagnosis) - Sexual behaviors; (decreased) appetite." At 5:00 p.m., Nursing Notes document "(R12) was in the dining room....when (R12) made a very inappropriate (sexual) gesture to a female (resident)....told (R12) it was inappropriate and we removed the female to another part of the (dining room)." At 6:00 p.m., Nursing Notes document, "(R12) watched female (resident) walk</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>out of (dining room). (R12) smiled and got up to follow resident....nurse followed (R12) but (female resident) was not in his sight, so (R12) went into (R12's) room." A Nursing Note, dated 6/12/14 at 2:15 p.m., indicates R12 was placed on 1:1 observation, due to "behaviors."</p> <p>Investigation Assessment/Resident to Resident Aggression form, dated 6/11/14, documents R12, "grabbed (R33's) buttocks and R33 turned and hit (R12) with a doll."</p> <p>On 6/19/14 at 1:10 p.m., E30 (Licensed Practical Nurse) stated R12 does try to intimidate the residents on the Alzheimer's Unit, specifically R33. E30 stated R12 "scares me" and "(R12) knows what (R12) is doing," but was uncertain if R12's behaviors met the definition of abuse.</p> <p>On 6/19/14 at 12:50 p.m., E2 (Director of Nursing) stated (E2) recalls being notified of R2's threatening verbal behavior on 6/02/14 and stated the nurse on duty was instructed to remove R12 from the presence of other residents for the remainder of the night, as "(R12) does not always deescalate." E2 was uncertain as to why R12 was allowed to remain in the presence of other residents (on 6/02/14), enabling R12 to interact with a female resident. E2 stated, "every time staff called me about (R12's) sexual advances to residents, I instructed staff to keep (R12) away from the female residents." E2 concluded, R12's behaviors were why R12 was eventually put on 1:1 observation, but not until 6/12/14.</p> <p>On 6/18/14 at 10:15 a.m., E1 stated that residents having abusive behaviors, including those of a sexual nature directed towards others, need to be separated from others to ensure all residents are protected. E1 stated (E1) was</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>aware R12 was "having behaviors, but did not know they were sexual in nature or that (R12) grabbed a resident's bottom."</p> <p>The Resident Census and Condition Report, dated 6/16/14 and signed by E1 (Administrator), documents 97 residents reside in the facility.</p> <p>(A)</p> <p>300.610a) 300.1010h) 300.1210b) 300.1210d)5) 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. 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.</p> <p>Section 300.1010 Medical Care Policies</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER MORTON TERRACE H & R CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 191 EAST QUEENWOOD ROAD MORTON, IL 61550
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S9999	<p>Continued From page 12</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</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>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</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER MORTON TERRACE H & R CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 191 EAST QUEENWOOD ROAD MORTON, IL 61550
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S9999	<p>Continued From page 13</p> <p>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> <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 interview, observation, and record review, the facility failed to accurately assess, implement interventions, notify the physician of changes in skin condition, update the care plan of changes in skin condition, and document as required by their facility policy to prevent the development of a pressure ulcer for one of four residents (R3) reviewed for pressure ulcers in the sample of twenty. This failure resulted in R3 developing two Stage III pressure ulcers.</p> <p>Findings include:</p> <p>R3's Physician Order Sheet dated 06/12/14 through 07/11/14 documents R3's diagnoses to include: deconditioning, weakness, diabetes, and dementia with behaviors.</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER MORTON TERRACE H & R CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 191 EAST QUEENWOOD ROAD MORTON, IL 61550
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S9999	<p>Continued From page 14</p> <p>On 06/16/14 at 9:07 a.m., E6, Restorative/Wound Nurse, stated R3 currently has, "excoriation," to R3's buttocks. At that time, E6 stated that R3 had no pressure ulcers.</p> <p>Facility's current Pressure Ulcer Report dated 06/16/14 contains no documentation of pressure areas for R3.</p> <p>On 06/18/14 at 8:45 a.m., E6, Restorative/Wound Nurse, stated R3 is a high risk for development of pressure ulcers due to R3's immobility and past skin issues, including a pressure ulcer in January 2014. However, R3's Braden Scale dated 07/22/13, 10/16/13, 01/10/14 and 04/04/14 document R3 is a moderate risk for pressure ulcer development.</p> <p>R3's Nurse's Notes written by E29, Licensed Practical Nurse, dated 06/07/14, document, "Areas on both inner buttocks have superficial open areas, skin peeling, small amount of bleeding. Areas cleaned and dressings applied at this time."</p> <p>On 06/19/14 at 11:42 a.m., E29, Licensed Practical Nurse, stated, "(R3) had a new area to (R3's) left and right buttocks on 06/07/14. It was open and draining. Very excoriated like a diaper rash. I (E29) applied barrier cream and covered the areas with guaze." E29 then stated E29 did not notify R3's physician or the wound nurse of the change in R3's skin condition on 06/07/14.</p> <p>On 06/18/14 at 2:10 p.m., E6, Restorative/Wound Nurse, stated E6 was unaware of R3's skin issues on 06/07/14. E6 then stated that E6 would expect to be notified of R3's skin issues and verified that no new intervention was implemented and R3's care plan was not updated</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER MORTON TERRACE H & R CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 191 EAST QUEENWOOD ROAD MORTON, IL 61550
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S9999	<p>Continued From page 15</p> <p>after discovery of R3's skin issues on 06/07/14.</p> <p>On 06/17/14 at 11:13 a.m., E6 Restorative/Wound Nurse, performed a dressing change to R3's right buttocks pressure ulcer. R3 had a 6x6 inch round excoriated area to R3's right buttocks with a 2x1 inch comma-shaped area of eschar tissue and a 1x1 round area of eschar tissue noted within the excoriated area. E6 stated R3's skin issues were first brought to E6's attention on 06/12/14 and R3's buttocks was, "denuded," at that time. E6 then stated the denuded areas to R3's left and right buttocks progressed and developed into two Stage III pressure ulcers sometime between 06/12/14 to 06/16/14, one pressure ulcer on R3's left buttocks and the other on R3's right buttocks. Medical records for R3 for that time frame contain no documentation of R3's buttocks being assessed or any worsening of R3's skin.</p> <p>R3's left buttocks was unable to be observed due to R3's refusal of a dressing change on 06/17/14.</p> <p>Facility's Wound Care policy (revised May 2014) and Pressure Ulcer policy (revised October 2010) both state, "Documentation in the clinical record may include: The type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name and the title of the person performing the wound care, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints made by the resident during the procedure, if the resident refused the procedure and the reasons why, and the signature and title of the person recording the data."</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>R3's Physician Order dated 06/12/14 documents, "Bilateral gluteals: cleanse areas with wound cleanser. Pat dry. Apply skin prep to wound. Apply thin hydrocolloid dressings. Change every 3 days and as needed."</p> <p>R3's Physician Order dated 06/17/14 documents, "Right and left buttocks: cleanse with wound cleanser. Pat dry. Apply medihoney alginate to wound bed. Cover with hydrocolloid dressings. Change every 3 days and as needed."</p> <p>R3's Treatment Administration Record dated 06/12/14 to 07/11/14 documents the above ordered wound care was administered to R3 on 06/12/14, 06/16/14, and 06/17/14.</p> <p>R3's current medical record includes no documentation of wound assessments between 06/08/14 and 06/16/14.</p> <p>R3's current care plan has no mention of R3's change in skin condition on 06/07/14 or 06/12/14.</p> <p>On 06/19/14 at 10:55 a.m., E6, Restorative/Wound Nurse, verified R3's care plan was not updated on 06/07/14 or on 06/12/14 when R3's skin issues were brought to E6's attention and there is no documentation pertaining to R3's left and right buttocks wounds from 06/08/14 to 06/16/14.</p> <p>On 06/17/14 at 1:25 p.m., Z3, R3's physician, stated Z3 was not notified of R3's change in skin condition on 06/07/14 and also stated R3's rapid progression of the denuded areas to R3's left and right buttocks to 2 Stage III pressure ulcers was avoidable.</p>	S9999		
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S9999	Continued From page 17 <p style="text-align: center;">(B)</p>	S9999		
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Morton Terrace Healthcare and Rehabilitation Centre
191 East Queenwood Road
Morton, IL 61550

F223

The facility makes every effort to ensure residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

Corrective actions have been completed for those residents found to have been affected by the deficient practice;

1. R 2

On 06/18/2014 the following actions occurred. R2 was transferred to a private room and remains on 1:1 supervision while out of room, until seen by a psychiatrist. A pharmacist review was completed. The physician was notified of behavioral symptoms, and the care plan was reviewed and revised to minimize risk of abuse.

2. R12 – No longer resides at the facility.

On 06/18/2014 the following actions occurred. R12 was sent to the hospital for evaluation of behavioral symptoms. On 6/19/2014 a petition for involuntary psychiatric admission was completed. An emergency involuntary discharge was completed following documentation by physician that R12 is unable to be at the facility related posing a danger to other residents.

3. E1 and E2 have received additional instruction on the standards related to abuse prevention and investigation, including immediate steps to protect and prevent additional abuse during investigations, immediate reporting to state specific agencies and thorough investigation.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

- On 6/18/2014 all residents on the Alzheimer's Unit were identified as having potential to be affected. At risk for abuse assessments were completed on those residents and care plans were revised and interventions implemented.
- A QA audit of residents in the facility to identify additional residents having the potential to be affected. Care plans will be revised and interventions implemented as clinically indicated.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.

- On 6/18/2014 staff education was provided regarding the facility's Abuse Prevention Policy and Procedures to identify report and investigate abuse.
- Additional education will be provided for staff specific to policy and procedure for identification, reporting and abuse investigation.
- The Process for preventing abuse will be reviewed including policies and procedures. Changes will be made as clinically indicated.

Quality Assurance Plans to monitor facility performance to make sure corrections are achieved and are permanent.

- On 6/19/2014 monitoring began every shift, every day for 14 days. Ad Hoc QA meeting was held and the trend identified is that staff has a consistent understanding of abuse and reporting. Monitoring was modified to a minimum of 3 times per week.
- The Administrator or designee will be responsible for ongoing monitoring to ensure performance improvement specific to reporting and investigating potential abuse.
- Trends and/or concerns from audits will be reported to the QAPI committee for review and identification of changes in monitoring based on outcomes.

Dates when corrective action will be completed July 16, 2014 .

Morton Terrace Healthcare and Rehabilitation Centre
191 East Queenwood Road
Morton, IL 61550

F225

The facility makes every effort to ensure that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately to the administrator and to other officials in accordance with state law through established procedures; and are investigated thoroughly while preventing further potential abuse.

Corrective actions have been completed for those residents found to have been affected by the deficient practice;

1. R 2

On 06/18/2014 the following actions occurred. R2 was transferred to a private room and remains on 1:1 supervision while out of room, until seen by a psychiatrist. A pharmacist review was completed. The physician was notified of behavioral symptoms, and the care plan was reviewed and revised to minimize risk of abuse.

R12 – No longer resides at the facility

R20 – No longer resides at the facility

R22 – At risk for abuse assessment has been completed. The care plan has been revised and interventions implemented to minimize risk.

2. R12 – No longer resides at the facility.

On 06/18/2014 the following actions occurred. R12 was sent to the hospital for evaluation of behavioral symptoms. On 6/19/2014 a petition for involuntary psychiatric admission was completed. An emergency involuntary discharge was completed following documentation by physician that R12 is unable to be at the facility related posing a danger to other residents.

R33 - At risk for abuse assessment has been completed. The care plan has been revised and interventions implemented to minimize risk.

3. R7

Re-evaluation of behavioral symptoms will be completed to identify root cause. Referrals will be made as clinically indicated. Care plan will be revised with interventions implemented to minimize risk.

4. E1 and E2 have received additional instruction on the standards related to abuse prevention and investigation, including immediate steps to protect and prevent additional abuse during investigations, immediate reporting to state specific agencies and thorough investigation.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

- On 6/18/2014 all residents on the Alzheimer's Unit were identified as having potential to be affected. At risk for abuse assessments were completed on those residents and care plans were revised and interventions implemented.
- A QA audit of residents in the facility to identify additional residents having the potential to be affected. Care plans will be revised and interventions implemented as clinically indicated.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.

- Education has been and/or will be completed on reporting of potential abuse allegations, including but not limited to policy and procedures for abuse and reporting, and injuries of unknown origins.
- The facility has completed a review of the process for reporting allegations of potential abuse, including policies and procedures. Revisions have been or will be made as clinically indicated.

Morton Terrace Healthcare and Rehabilitation Centre
191 East Queenwood Road
Morton, IL 61550

F225 (cont.)

Quality Assurance Plans to monitor facility performance to make sure corrections are achieved and are permanent.

- On 6/19/2014 monitoring began every shift, every day for 14 days. Ad Hoc QA meeting was held and the trend identified is that staff has a consistent understanding of abuse and reporting. Monitoring was modified to a minimum of 3 times per week.
- The Administrator or designee will be responsible for ongoing monitoring to ensure performance improvement specific to reporting and investigating potential abuse.
- Trends and/or concerns from audits will be reported to the QAPI committee for review and identification of changes in monitoring based on outcomes.

Dates when corrective action will be completed July 16, 2014

Morton Terrace Healthcare and Rehabilitation Centre
191 East Queenwood Road
Morton, IL 61550

F226

~~The facility makes every effort to develop and operationalize policies and procedures for screening and training employees, protection of resident and for the prevention, identification, investigation and reporting of abuse, neglect, mistreatment, and misappropriation of property.~~

Corrective actions have been completed for those residents found to have been affected by the deficient practice;

1. R 2

On 06/18/2014 the following actions occurred. R2 was transferred to a private room and remains on 1:1 supervision while out of room, until seen by a psychiatrist. A pharmacist review was completed. The physician was notified of behavioral symptoms, and the care plan was reviewed and revised to minimize risk of abuse.

R12 – No longer resides at the facility

R20 – No longer resides at the facility

R22 – At risk for abuse assessment has been completed. The care plan has been revised and interventions implemented to minimize risk.

2. R12 – No longer resides at the facility.

On 06/18/2014 the following actions occurred. R12 was sent to the hospital for evaluation of behavioral symptoms. On 6/19/2014 a petition for involuntary psychiatric admission was completed. An emergency involuntary discharge was completed following documentation by physician that R12 is unable to be at the facility related posing a danger to other residents.

R33 - At risk for abuse assessment has been completed. The care plan has been revised and interventions implemented to minimize risk.

3. R7

Re-evaluation of behavioral symptoms will be completed to identify root cause. Referrals will be made as clinically indicated. Care plan will be revised with interventions implemented to minimize risk.

4. E1 and E2 have received additional instruction on the standards related to abuse prevention and investigation, including immediate steps to protect and prevent additional abuse during investigations, immediate reporting to state specific agencies and thorough investigation.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

- On 6/18/2014 all residents on the Alzheimer's Unit were identified as having potential to be affected. At risk for abuse assessments were completed on those residents and care plans were revised and interventions implemented.
- A QA audit of residents in the facility to identify additional residents having the potential to be affected. Care plans will be revised and interventions implemented as clinically indicated.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.

- Education has been and/or will be completed on reporting of potential abuse allegations, including but not limited to policy and procedures for abuse and reporting, and injuries of unknown origins.
- The facility has completed a review of the process for reporting allegations of potential abuse, including policies and procedures. Revisions have been or will be made as clinically indicated.

Morton Terrace Healthcare and Rehabilitation Centre
191 East Queenwood Road
Morton, IL 61550

F226 (cont.)

Quality Assurance Plans to monitor facility performance to make sure corrections are achieved and are permanent.

- On 6/19/2014 monitoring began every shift, every day for 14 days. Ad Hoc QA meeting was held and the trend identified is that staff has a consistent understanding of abuse and reporting. Monitoring was modified to a minimum of 3 times per week.
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- Trends and/or concerns from audits will be reported to the QAPI committee for review and identification of changes in monitoring based on outcomes.

Dates when corrective action will be completed July 16, 2014