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F 000	INITIAL COMMENTS Annual Certification Survey An Extended Survery was conducted.	F 000		
F 225 SS=F	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to report allegations of abuse immediately to the Administrator, delayed the initial investigation of abuse, accurately report abuse allegations to the Department, and thoroughly investigate all abuse allegations, including bruises of unknown origin. This has the potential to affect all 91 residents living in this facility. Findings include: 1. A final report to the Department for R20, dated 1/22/15, documents in part: "(R20) stated on 1/15/15 at 11:30 PM to a CNA (Certified Nurse Assistant), that another staff member 'slapped me in the face.' Immediately the CNA reported the statement to the nurse. The nurse immediately spoke to (R20) who then stated, 'she (CNA) slapped me on the arm (holding her left arm)' and reporting that the incident happened around 9:30 PM while she was preparing for bed. (R20) also gave a description of the accused staff member. The nurse assessed the resident's arm with no apparent redness, bruising, nor swelling. The nurse returned to the Nurses Station, called the DON (Director of Nursing)/interim Administrator, sent immediate notification to (the Department) and notified MD (Medical Doctor) staff member. The following day, the day shift nurse was instructed to speak to (R20) and let the	F 225		

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resident (R20) confide the incident she reported (R20) stated essentially the same happenings except she insisted that it was her right arm that was struck..."

R20's undated Nurses Note, written by E16, Licensed Practical Nurse (LPN), documents: "At 11:30 PM the night of 1/15/15, (E12, CNA) approached this nurse stating that (R20) stated she was slapped in the face by a colored girl. This nurse proceeded to (R20's) room asking what happened. (R20) replied 'I went over at 9:30 PM (pointing to her roommate side of the room) and was getting ready for bed and I went to turn the light out when the girl slapped my arm (holding her left arm). She was the wide black girl with long curly hair and funny looking earrings.' 'She told my aid (sp) don't turn it off again!' This nurse explained to (R20) she (E16) would take care of it. This nurse proceed to call (E2, DON) as soon as left (R20's) room. No injuries or redness noted. Notified state of occurrence."

R20's Nurses Note, dated 1/16/15 at 8:30 AM written by E13, LPN, documents: "Nurse approached (R20) to ask (R20) what happened last night- (R20) stated she got up in her room to turn roommates light off because she was ready for bed, as she pulled the light a CNA slapped her Right forearm 'as hard as she could' stated (R20). Nurse asked (R20) to describe CNA-(R20) said 'it was a black girl, stood about a head taller than I am had curly hair and big dangling earrings.' Nurse looked at (R20's) right arm- noted a 0.5 cm (centimeter) old fading purple bruise-(R20) didn't know how bruise got there. no c/o (complaint of) pain to arm noted at this time-will observe."

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R20's undated Nurses Note written by E14, CNA documents: "(R20) told me that she was in the bathroom on the potty and that both bathroom doors were open and she asked an aid (sp) to close the bathroom door. Then (R20) said the aid went off on her. This was a second shift aid. (R20) said the aid was black with short curly hair and glasses and she had big earrings on. (R20) said that she thinks this aid has it in for for her, and that she's (R20) scared of her."

An interview written by E2, DON on 1/16/15, documents: "(E18) CNA, came to my office as requested to make a statement related to an accusations of abuse by a resident. The resident identified the CNA as curly headed, black, wears, glasses, not heavy, very loud. Without making a statement, (E18) began to shout 'You have accused me of abuse before and I am tired of you accusing me of abuse.' I (E2) explained to (E18) that I was not making an allegation of abuse but rather investigating the residents statement that someone with that description hit the resident on the arm and told her to not turn the light on again. (E18) continued to shout and point her finger at this nurse stating, 'you aint' going to harass me like this...' At that point, I felt (E18) had escalated to the point that she could not be reasoned with and she was asked to leave my office.."

In an interview on 8/27/15 at 10:21 AM, E2 stated that she doesn't edit the Nurses Notes and that she just does the final report and sends it to the Department. When asked about the discrepancies between the staff members documented interviews that R20 was consistent with her account of being hit on the arm and the final report documenting R20 had stated she was "slapped in the face," E2 shrugged her shoulders

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and stated "I don't edit the nurse's document." E2 further stated at the time of R20's allegation, the Facility did not have a licensed Administrator and she was the acting un-licensed Administrator at that time.

2. R22's Investigation Document, dated 2/5/15 at 10:00 AM, documents: "CNA reported to this nurse (E19, LPN) large purple bruise to left inner thigh. Bruise is purple/grey in color and the size of a golf ball. Mental Status: A & O (alert and oriented) x 3. Name of physician notified: (Z1, Physician) 3:30 PM. Director of Nursing notified- (left blank). Administrator notified- (left blank).

A Facility Notification, dated 2/6/15, un-timed, written by E3, Assistant Director of Nursing (ADON), documents: "Resident: (R22), Injury: bruise, Administrator notified: (dashed), DON notified: 2/6/15, Comment: (R22) noted with bruise of unknown origin to let inner thigh light purple and yellowing in color and measuring 4 cm round. (R22) unsure of how bruise happened. No abuse suspected. Full investigation to follow." A fax cover sheet attached documents the Notification was faxed to the Department on 2/6/15 at 1:42 PM. This was over 27 hours after the injury of unknown origin was initially identified.

R22's Nurses Note, dated 2/5/15, written by E19, LPN, documents: "When giving (R22) her IM (intramuscular) Rocephin injection tonight, CNAs showed me a large purple/grey bruise to (R22's) right inner thigh. (R22) said that it came because a CNA is always too rough with her. (R22) described what sounded like (E17) to me. (R22) said she (E17) is always too rough with her. (E17) has been on B/D hall for the past week thou so I don't know. When (R22) told me about

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it she didn't seem scared. She also had faint purple bruises to lower right ankle area that resembles fingers. I did not chart in nurses notes but I noted bruise in TAR (Treatment Administration Record.)"

A note, dated 2/6/15 at 9:45 AM, written by E3, ADON, documents: "area to left inner thigh yellow/purple bruise- noted by (E3, E7, Care Plan Coordinator, and E13, LPN). (R22) states when asked what is that bruise from? 'I don't know' (R22) said 'some times the girls are a little rough. But it will go away.' (R22) denies pain...Area noticed on 2/5/15 shower sheet and signed by (E20, LPN). Noted on 2/5/15 skin check by (E21, LPN) and reported by nurse (E19, LPN) on a note 2/5/15 and left to be read 2/6/15 AM."

R22's Nurses Note, dated 2/6/15 at 1:30 PM written by E13, LPN, documents: "(E3) ADON and I laid (R22) down in bed, observed fading yellow and purple 4 cm round bruise to left inner thigh. (R22) does not know where it could have come from- no pain or discomfort noted at the site- noted brown discoloration to left lower extremity."

The Final Report, dated 2/11/15, documents, in part: "On 2/5/15, during a shower, it was noted that this resident (R22) had a faded, yellow/green bruise to the left inner thigh. (R22) was not able to relate how the bruise happened other than 'I get bruises all the time.' No specific incident was noted by (R22) to establish cause of this bruise. No discomfort was associated with the exam of the bruise and (R22) denies pain to the area. The area measures 2.0 by 2.0 and round. (R22) is able to relate daily happenings therefore no abuse is suspected as the cause of this bruise of

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unknown origin." The document is signed by E2, DON. The Administrator signature is missing.

In an interview on 8/27/15 at 10:21 AM, E2 stated that she doesn't edit the Nurses' notes and that she just does the final report and sends it to the Department. When asked if staff members who had cared for R22 were interviewed, E2 stated she did not interview any staff members in R22's direct care nor did she interview other residents E2 stated that E17, CNA who was specifically named when R22 had stated the "girls are rough" was not interviewed during this investigation. E2 further stated at the time of R22's allegation, the Facility did not have a licensed Administrator and she was the acting un-licensed Administrator at this time.

On 8/31/15 at 11:00 AM, E3, ADON stated she was left a note on 2/5/15 by E19, LPN regarding R22's bruising. E3 stated she came in the next day on 2/6/15 and read the note and the investigation began on 2/6/15.

3. The Facility's Final Report, dated 1/8/15, documents in part: "On January 3, 2015, (R24) stated to a CNA, 'Are you going to hit me?' After much reassurance and consoling, (R24) stated to the CNA that she had been hit by a staff member two days prior and she could not identity them other than 'they had black hair.' Immediately the CNA called the Director of Nursing/Administrator.." E2, DON signed the report, the Administrator's signature area is left blank.

The Facility's Notification document, dated 1/3/15, documents, in part: "injury: no apparent injury, Administrator notified: (left blank), DON notified:

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yes, Comment: this is a reported incidence of abuse from (R24), age 85, stated she was hit by an unidentified staff member."

R24's Nurses Note, dated 1/3/15 at 12:20 PM, written by E22, CNA, documents: "staff was walking (R24) to her room to change clothes. While walking down hall (R24) asked staff 'Are you going to hit me?' staff replied 'No, I wouldn't do that.' (R24) asked staff 2 more times 'are you going to hit me?' Staff asked (R24) 'Is someone hitting you.' (R24) said 'Yes.' Staff asked 'where did they hit you?' (R24) replied 'in my belly.' Staff asked 'what did they hit you with?' (R24) replied. 'their fist.' Staff asked (R24) 'Why did they hit you' (R24) replied 'I don't know, I didn't ask.' Staff asked (R24) 'What did they look like?' (R24) replied 'they had black hair.' Staff asked (R24) 'were they black or white?' (R24) replied 'I don't know.' Staff notified nurse and called (E2) DON."

R24's Shower sheet, dated 1/3/15, documents 2 areas on pictorial graph of body on left and right lower abdomen and description that states "light pink area under abdominal fold.

R24's Nurses Note, dated 1/3/15 written by E23, LPN documents: "Upon performing head to toe assessment of (R24), I asked (R24) what had happened- (R24) stated 'nothing happened to me.' I asked (R24) if someone hit her in the stomach. (R24) stated 'no.' Asked (R24) this question x 2-replied 'no' each time."

On 8/26/15 at 9:55 AM, E2, DON, stated she was called at home by E23, LPN because it was a weekend. E2 stated she told E23 to give R24 time and then go question R24. E2 stated that she did not speak with R24 until the following

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Monday and stated that R24 acted like she didn't want to talk to me. E2 stated she does not have any other statements from any other staff members or any residents because they did not interview anyone. E2 stated she didn't think R24's allegation "was plausible."

4. R25's Investigation Document, undated, with a time of 12:00 PM documents: "(R25) alert x 2-3, brief description: 98 year old female complained of thumb injury upon arising this AM with assist of CNA." The Director of Nursing and Administrator notification is left blank

The Facility's Notification Report, dated 6/27/15, documents: "injury: c/o (complaint of) thumb hurting, Administrator notified: (left blank), DON notified: yes 6/27/15, Comment: (R25) 98 year old female, reported injury to right thumb upon arising with assist of CNA."

R25's Nurses Note, dated 6/27/15 at 12:25 PM, written by E26, LPN, documents in part: "(R25's) POA (Power of Attorney) came to the desk and stated 'I just heard from my mom that the girl who got her up this morning was very rough and hurt her thumb, it looks disjointed to me.' I told (R25's) POA that I had been told nothing about it from (R25) and assured him I would check it out. When I approached (R25), she was sitting in her wheelchair and stated 'that girl that got me up this morning, I told her to wait a minute, I wasn't ready and felt myself sliding, she just went anyway, put me in the chair.' (E25, CNA) stated 'Oh, you hurt my back!' and (R25) stated 'well you hurt my thumb!' I was sitting at the desk this morning at the beginning of shift heard (E25) tell the night shift nurse she felt like she was passing another kidney stone that her back was hurting her very

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bad. (E25) didn't mention hurting (R25)."

R25's Nurses Note, dated 6/27/15 written by E27, CNA documents in part: "(R25) stated that a nurse earlier pulled her arm and dislocated her shoulder..When trying to remove (R25's) shirt she stated 'that hurts me'."

R25's Nurses Note, dated 6/27/15 written by E28, CNA, documents in part: "(R25) stated that earlier in the day a nurse had pulled on her arm and had dislocated her shoulder.."

R25's Nurses Note, dated 6/27/15 written by E29, CNA, documents: "(E25) and I worked together to get (R25) washed, dressed and transferred in to her wheelchair. (R25) did not complain of pain. (R25) did not help with bearing weight, she pushed back and slid feet forward. We informed (R25) if she did not help with bearing weight she could hurt herself or the staff."

R25's Nurses Note, dated 6/27/15 written by E24, LPN, documents in part, "(E25 and E29, CNA's) helped (R25) with morning care and transferred (R25) with gait belt."

E2's notes on the fax cover sheet documented an interview with R25 on 6/29/15: "(R25) states 'I have been so roughed up I don't know where to start. The nurse broke my shoulder, I don't know anything about a thumb, I did not hurt thumb. Everybody is rough'."

On 8/26/15 at 9:55 AM, E2, DON, stated that R25's allegation of staff being rough happened on a weekend and she received a call at home from E26, LPN, and that is why she didn't interview her until 6/29/15. E2 also stated that the CNA, E25,

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that was working with R25 the date and time in which the allegation occurred was not interviewed and was never suspended pending investigation into R25's allegation. E2 also stated that she contacted E1, Administrator, after the allegation was reported to her.

On 8/26/15 at 10:10 AM, E2, DON stated that "(E1) is the Abuse Coordinator, but the nursing staff and CNA's will contact me first because it is the chain of command. I will then let (E1) know, but staff knows they can call him." E2 further stated that the facility policy says investigate allegations of abuse and come to a conclusion. E2 states "to never discount anyone's statement- it's clear with (R2's) dementia she perceives things in a different way. I know my residents and absolutely know that yes-if you can illicit the same story 20 minutes later- but even if you can't, you still look into it."

On 8/26/15 at 10:50 AM, E1, Administrator, stated he was not employed by this facility until 4/1/2015 and has no knowledge of the previous abuse investigation cases. E1 further stated he is unaware who was the acting Administrator previous to his employment. E1 also stated that the facility policy that was given upon entrance is accurate and the policy in use and that it is not followed. E1 stated that E2 does nursing allegations and "spearheads" the investigations. E1 further stated that he has not had very many calls off hours for abuse allegations- "don't get a lot from staff."

5. R6's Minimum Data Set (MDS), dated 8/09/2015, documents R6 is severely impaired with cognition, and requires extensive assistance with transfers and all ADL's (activities of daily

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living). The Physician Order Sheets (POS) for 8/2015 has no documentation R6 has any orders for aspirin or an anticoagulant medication that could increase the risk of bleeding or bruising.

On 8/26/2015 at 9:17 AM, R6 was propelling herself around the facility in a wheelchair. A self releasing, alarmed seat belt and anti-tippers were on R6's wheelchair. R6 had a large purple bruise covering the top of the left hand. R6 was confused and mumbling incoherently.

On 8/26/2015 at 11:40 AM, E6, LPN, was asked how R6 sustained the large bruise to the left hand. E6 stated, "I was not aware it was there. She had a BMP (basic metabolic profile blood test) 8/20/2015. I'll take a look at it and see. Or she popped her hand on something." At that time, there was no documentation of a bruise to R6's left hand in the Nurses Notes.

R6's Nurses Note, dated 8/26/2015 at 12:00 PM, documents the dark purple bruise to R6's left hand with physician notification.

On 8/26/2015, at 1:22 PM, E6 stated, "I wonder if they got the wrong hand. It's (the bruise) not documented anywhere." The laboratory requisition, dated 8/20/2015 for a BMP for R6, documented the blood sample was obtained from the right hand.

On 8/27/2015 at 1:25 PM, E2, DON, was asked if R6's bruise was investigated to try to determine the cause. E2 stated, "No, not yet. I did talk to (E6) about it yesterday (8/26). She (E6) told me she (R6) had a blood draw, and it was documented to have been done to the right hand. (R6) does wander around the building and run

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into things. I don't know really. I'll look into it."

The initial Department notification of R6's bruise of unknown origin was documented from E1, Administrator as faxed on 8/27/2015 at 1:41 PM. This was over 24 hours after the bruise was first identified.

6. A Report of Serious Incident or Accident, dated 5/26/15, sent to the Department documents, in part, "Resident name: (R23), Date of Incident: 5-21-15: On May 21, 2015 she reported to a CNA that a CNA on the previous shift 'slammed' her onto the bed when she attempted to get up. Immediate notification was sent to (the Department), (Z1) was notified, and her POA, daughter (Z3) was immediately notified. The daughter stated at that time that (R23) had used that term even while she was home and no one was in attendance. (R23) is extremely paranoid and believes several people, living and dead, are in the room at all times. (R23) stated to this nurse 'well, do you think my grandmother did it. She just sits there. She would not have put me back on the bed.' The daughter is an RN (Registered Nurse) who has experience with residents with Dementia/Lewy Bodies and a written statement provided by her is part of this investigation. In conclusion, no evidence of abuse was discovered and the causation of this incident is ongoing progressive decline in cognitive status." This report is signed by E2, DON and is not signed by the Administrator.

A statement written by Z3 regarding R23, dated 5/21/15, documents R23 has been using the phrase "slammed" to refer to any jolt, mis-step or when she sits on her bed. Z3 documented R23 used that phrase at home and used it tonight to

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F 225	Continued From page 13 tell me her roommate was "slammed" this AM- not her. Z3 then stated, "I see no evidence of abuse or neglect of any kind." The Facility's Notification Document, dated 5/21/15, documents, "Injury: none, Administration Notified: 5/21/15 (no time), DON notified: 5/21/15 (no time), Comment: 83 year old resident female with diagnosis of Dementia with Lewy Bodies indicated CNA from previous shift pushed her down on bed. Further investigation to follow. On 8/26/15 at 9:55 AM, E2, stated the CNA reported to her nurse, the nurse went to the ADON (E3) stating that R23 was slammed down on her bed. E2 stated she only got an interview from Z3 and Z3 did not want the incident reported to the Department because R23 had been doing that for years. E2 stated she made Z3 aware that the facility is obligated to do a full investigation on any allegations. E2 stated that Z3 was told by R23 that it was her roommate that had been slammed and not her. E2 stated she did not interview the roommate, or any other staff member or residents regarding this allegation. 7. The Resident Census and Conditions of Residents, CMS 672, dated 8/24/15, documents that the facility has 91 residents living in the facility.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow it Abuse policy by not reporting allegations of abuse immediately to the Administrator, allowing a Certified Nurse Assistant to have direct contact with residents after potential incidents of abuse, delaying the initial investigations of abuse, accurately report abuse allegations to the Department, and thoroughly investigate all abuse allegations, including bruises of unknown origin. This has the potential to affect all 91 residents living in this facility.

Findings include:

1. Facility's Abuse Prevention Program Policy and Procedure, undated, documents in part: "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: Orienting and training employees on how to recognize and report occurrences of mistreatment neglect and abuse, identifying occurrences and patterns of potential mistreatment, immediately protecting residents involved in identified reports of possible abuse, implementing systems to investigate all reports an allegation of mistreatment promptly and aggressively and making the necessary changes to prevent future occurrences and filing accurate and timely investigative reports.
The nursing staff is responsible for reporting on a facility incident report the appearance of bruises, lacerations or other abnormalities as they occur. Such occurrences shall be reported to the

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F 226	Continued From page 15 Administrator. The Director and/or Assistant Director of Nursing (ADON) is responsible for reviewing the incident report and reporting findings to facility Administrator. 4. Internal Reporting Requirement and Identification of Allegations: All residents, visitors, volunteers, family member or others are encouraged to report their concern or suspected mistreatment to a supervisor and/or the administrator immediately. Upon learning of any report of suspected mistreatment, the administrator shall initiate an investigation. If the administrator has determined that there is reasonable abuse to suspect that mistreatment may have occur, the residents' representative, physician and IDPH will be notified immediately. 5. Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway. Employees of this facility who have been accused or suspected of resident abuse, neglect or misappropriation of property will be moved from resident contact immediately until the results of the investigation have been reviewed by the administrator. 6. Internal Investigation of Allegation and Response: a. Administrator as the facility abuse Prohibition Coordinator, will immediately begin an investigation into an allegation or suspicious of resident mistreatment. The nursing staff is responsible for reporting on a facility incident report the appearance of bruises, lacerations or other abnormalities as they occur. Such occurrences shall be reported to the Administrator. The Director and/or Assistant Director of Nursing (ADON) is responsible for reviewing the incident report and reporting findings to facility Administrator." 2. R20's final report to the Department, dated	F 226		

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F 226	Continued From page 16 1/22/15, documents an allegation by R20 on 1/15/15 that a staff member slapped her in the face. There is no documentation that any other residents or staff were interviewed for this investigation. The final report does not reflect the same story from interviews with R20 by others staff documented in the Nurses Notes. In R20's Nurses Note, dated 1/16/15 at 8:30 AM, R20 described the alleged perpetrator. There is no documentation of attempts to identify anyone matching her description or that anyone was suspended until the investigation was completed. In an interview on 8/27/15 at 10:21 AM, E2, DON, stated that she doesn't edit the Nurses Notes and that she just does the final report and sends to the Department. When asked about the discrepancies between the staff members documented interviews that R20 was consistent with her account of being hit on the arm and the final report documenting R20 had stated she was "slapped in the face", E2 shrugged her shoulders and stated "I don't edit the nurse's document." E2 further stated at the time of R20's allegation, the Facility did not have a licensed Administrator and she was the acting un-licensed Administrator at this time. 3. R22's Investigation Document, dated 2/5/15 at 10:00 AM documents R22 had a large purple bruise to left inner thigh. There is no documentation that the Director of Nursing (DON) or Administrator were notified.	F 226		

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The Facility Notification, dated 2/6/15, un-timed, written by E3, Assistant Director of Nursing (ADON), documents: Resident: R22, Injury: bruise, Administrator notified: dashed, DON notified: 2/6/15, Comment: R22 noted with bruise of unknown origin to let inner thigh light purple and yellowing in color and measuring 4 cm round. R22 unsure of how bruise happened. No abuse suspected. Full investigation to follow. A fax cover sheet attached documents this was faxed on 2/6/15 at 1:42 PM. This was over 24 hours after R22's bruise was first identified.

The Final Report, dated 2/11/15, documents R22's bruise and that R22 is able to relate daily happenings therefore no abuse is suspected as the cause.
The Final Report does not reflect the interviews with R22 by other staff in which R22 alleged rough treatment by staff as the cause of the bruise and described the alleged staff perpetrator.

In an interview on 8/27/15 at 10:21 AM, E2, DON, stated that she doesn't edit the Nurses' notes and that she just does the final report and sends to IDPH. When asked if staff members who had cared for R22 were interviewed, E2 stated she did not interview any staff members in R22's direct care nor did she interview other residents E2 stated that E17, CNA who was specifically named when R22 had stated the "girls are rough" was not interviewed during this investigation. E2 further stated at the time of R22's allegation, the Facility did not have a licensed Administrator and she was the acting un-licensed Administrator at this time. There is no documentation that E17 was suspended pending investigation.

On 8/31/15 at 11:00 AM, E3, ADON stated she

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was left a note on 2/5/15 by E19, LPN regarding R22's bruising. E3 stated she came in the next day on 2/6/15 and read the note and the investigation began on 2/6/15.

4. The Facility's Final Report, dated 1/8/15, documents R24's allegation on 1/3/15 that she was hit by a staff member 2 days prior.

On 8/26/15 at 9:55 AM, E2, DON, stated she was called at home by E23, LPN because it was a weekend. E2 stated she told E23 to give R24 time and then go question R24. E2 stated that she did not speak with R24 until the following Monday and stated that R24 acted like she didn't want to talk to me. E2 stated she does not have any other statements from any other staff members or any residents because they did not interview anyone. E2 stated she didn't think R24's allegation "was plausible."

5. The Facility's Notification Report, dated 6/27/15, documents R25's reported injury to right thumb upon arising with assist of CNA.
The Notification Report does not reflect the interviews of R25 by other staff in which R25 alleged rough treatment by staff that hurt her thumb.

E2's notes on the fax cover sheet an interview with R25 on 6/29/15 documented: "(R25) states 'I have been so roughed up I don't know where to start. The nurse broke my shoulder, I don't know anything about a thumb, I did not hurt thumb. Everybody is rough.'"

On 8/26/15 at 9:55 AM, E2, DON, stated that R25's allegation of staff being rough happened on a weekend and she received a call at home and

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that is why I didn't interview her until 6/29/15. E2 further stated that E26, LPN was who called me at home to report allegation from R25. E2 also stated that the E25, CNA that was working with R25 the date and time in which the allegation was not interviewed. E2 stated that E25 was never suspended pending investigation into R25's allegation. E2 also stated that she contacted E1, Administrator after it was reported to her.

6. The Report of Serious Incident or Accident to the Department, dated 5/26/15, documents an allegation by R23 on 5/21/15 that a CNA slammed her on the bed. The Report also documents that no evidence of abuse was discovered.

On 8/26/15 at 9:55 AM, E2, stated the CNA reported to her nurse, the nurse went to the E3, ADON stating that R23 was slammed down on her bed. E2 stated she only got and interview from Z3 and Z3 did not want the incident reported to IDPH because R23 had been doing that for years. E2 stated she made Z3 aware that the facility is obligated to do a full investigation on any allegations. E2 stated that Z3 was told by R23 that it was her roommate that had been slammed and not her. E2 stated she did not interview the roommate, or any other staff member or residents regarding this allegation.
There is no documentation of any investigation of the allegation made by R23 to Z3 that her roommate had been slammed.

On 8/26/15 at 10:10 AM, E2, DON stated that "E1 is the Abuse Coordinator but the nursing staff and CNA's will contact me first because it is the chain of command." I will then let E1 know, but staff knows they can call him. E2 further stated that

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the facility policy says investigate allegations of abuse and come to a conclusion. E2 states "to never discount anyone's statement- it's clear with R2's dementia she perceives things in a different way. I know my residents and absolutely know that yes-if you can illicit the same story 20 minutes later- but even if you can't, you still look into it."

On 8/26/15 at 10:50 AM, E1, Administrator, stated he was not employment by this facility until April 1st, 2015 and has no knowledge of the previous abuse investigation cases. E1 further stated he is unaware of who the acting Administrator previous to his employment was. E1 also stated that the facility policy that was given upon entrance is accurate and the policy in use and that it is not followed. E1 stated that E2 does nursing allegations and "spearheads" the investigations. E1 further stated that he has not had very many calls off hours for abuse allegations- "don't get a lot from staff."

On 8/26/15 at 11:12 AM, E30, CNA was interviewed and stated "I would report abuse to my nurse and (E2) DON and (E3) ADON. We are trained to do that."

On 8/26/15 at 11:18 AM, E31, CNA stated "I would report abuse suspicious events to (E2) DON, then the Administrator. (E2's) phone number is in the breakroom."

On 8/26/15 at 11:30 AM, E32, CNA stated "I would go first to (E2) DON, and (E3) ADON for abuse/neglect allegations."

On 8/26/15 at 11:40 AM, E4, RN, stated, "I would report to (E1) DON and then Administrator. The

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phone numbers are located in the kardex."

On 8/26/15 at 11:45 AM, E9, CNA stated "if Administrator is not here I would report to (E2) DON. If neither of (E1) or (E2) are here, then the charge nurse."

7. On 8/26/2015 at 11:40 AM, E6, Licensed Practical Nurse (LPN) was asked how R6 sustained the large bruise to the left hand. E6 stated, "I was not aware it was there. She had a BMP (basic metabolic profile blood test) 8/20/2015. I'll take a look at it and see. Or she popped her hand on something." At that time, there was no documentation of a bruise to R6's left hand in the Nurses Notes.

The Nurses Note, dated 8/26/2015, at 12:00 PM documents the dark purple bruise to R6's left hand with the physician notification.

On 8/26/2015, at 1:22 PM, E6 stated, "I wonder if they got the wrong hand. It's (the bruise) not documented anywhere." The laboratory requisition dated 8/20/2015 for a BMP for R6 documented the blood sample was obtained from the right hand.

On 8/27/2015 at 1:25 PM, E2, Director of Nursing (DON) was asked if R6's bruise was investigated to try to determine the cause. E2 stated, "No, not yet. I did talk to (E6) about it yesterday (8/26). She told me she had a blood draw, and it was documented to have been done to the right hand. (R6) does wonder around the building and run into things. I don't know really. I'll look into it."

The initial Department notification of R6's bruise of unknown origin was documented from E1,

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F 226	Continued From page 22 Administrator as faxed on 8/27/2015 at 1:41 PM. This was over 24 hours after the bruise of unknown origin was first identified. 8. The Resident Census and Condition, dated 8/24/15, documents that the facility has 91 residents living in the facility.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to provide counseling and monitoring for suicidal/homicidal ideation for one of one residents (R14) reviewed for suicidal/homicidal ideations in the sample of 19. Findings Include: R14's Minimum Data Set (MDS) dated 8/10/2015 documents R14 was admitted 8/4/2015 with diagnoses, in part, of Dementia with psychosis and insomnia. R14's Nurses Note dated 8/8/2015 at 1:30 AM documents, in part, "Orders received from (physician) for Cipro 500 mg (milligrams) po (by mouth) bid (twice a day), Ativan 0.5 mg IM (intramuscularly injection) times 1, CBC (complete blood count), BMP (basic metabolic	F 250		

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panel) and TSH (thyroid stimulating hormone). Resident has been voicing suicidal and homicidal ideations and attempting to strike staff."

R14's Nurses Notes have no documentation regarding the nursing care R14 received after making suicidal/ homicidal ideations, the measures to ensure R14's safety, or R14's response to the Ativan IM.

There is no further documentation in R14's Nurses Notes until 9.5 hours later. R14's Nurses Note, dated 8/8/15 at 11:00 AM, documents, in part, "currently asleep in bed all shift easily awakens. Ate 75% with assistance no behaviors. Behaviors this past night reported to (physician) new orders received."

R14's Nurses Note, dated 8/8/2015 at 1:00 PM, documents, in part, "Power of Attorney made aware of new order for psychiatry evaluation."

E15, Social Service Director (SSD), documents on 8/10/2015 at 8:00 AM, "SSD was notified by DON (Director of Nurses) that resident voiced suicidal comments ideations to (nursing). SSD spoke with resident in reference to comments. Resident voiced no concerns and denies suicidal homicidal thoughts. SSD notified DON of conversation."

On 8/26/2015 at 11:30 AM, E2, DON, stated, "I expect the nurse to keep the resident in close visual range when displaying suicidal / homicidal behaviors. The nurse should have made another entry regarding behaviors and document that the resident was safe."

On 8/27/2015 at 12:30 PM, E15, stated, "If a

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F 250	Continued From page 24 resident has suicidal homicidal ideation staff is to notify me as soon as possible and keep an eye on the resident. I notify the DON of what has happened." On 8/27/2015 at 1:00 PM, E2, stated, "I was notified of (R14's) suicidal and homicidal ideations around 3:00 AM on 8/8/15. I made the determination (R14) was not imminent danger. If there is a resident who is uncontrolled and in imminent danger, we would notify the doctor and receive an order to send the resident to the hospital. I am unsure when (E15) was contacted about (R14's) suicidal homicidal ideations." On 8/27/2015 at 2:00 PM, E1, Administrator, stated, "The facility has no policy or procedure for handling residents that are suicidal homicidal."	F 250		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide supervision, effective safety interventions and safe transfers to prevent injury, ingestion of chemicals and multiple falls for 3 of 9 residents (R2, R3, R6) reviewed for falls and incidents in	F 323		

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the sample of 19.

Findings include:

1. The Physician's Order Sheet (POS) for 8/2015 documents R6 has diagnoses, in part, of Vascular Dementia, Depression with Disruptive Behavior, Abnormality of Gait and Degenerative Joint Disease (DJD). The Minimum Data Set (MDS), dated 8/09/2015, documents R6 is severely impaired with cognition, wanders daily, requires extensive assistance with transfers, is nonambulatory and has limited range of motion to all extremities.

The Fall Risk Assessments, dated 11/02/14, 12/25/14, 1/05/15, 7/05/15 and 8/10/15 document R6 is a high risk for falls and to initiate Fall Prevention Protocol II. The PT (Physical Therapy) Evaluation, dated 6/09/15, documents, in part, "Unable to follow directions. Can be resistive."

On 8/26/2015, R6 was unsupervised and propelling herself around the facility, seated in a wheelchair, in the following areas: D hall at 9:10 AM and into room D-1, A hall at 10:30 AM, dining room at 10:55 AM, front office at 11:00 AM, dining room at 11:33 AM, A hall at 1:12 PM, and then into room A7 (not R6's room). R6 was confused, talking nonsensically and mumbling to herself. An alarmed, self release safety belt was around R6's waist. Anti-tippers were on the back of the wheelchair. R6 had a large purple bruise covering the top of her left hand.

The Incident Investigations document R6 has had unwitnessed falls, without injury, after attempts to self transfer on 9/17/14, 9/21/14, 11/02/14 and 11/07/14. The analysis of the falls document all

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safety alarms were sounding, and R6 has cognitive deficits with poor safety awareness. All of these falls were documented as occurring on the evening shift.

The Incident Investigation, dated 11/17/14 at 9:45 PM, documents R6 entered the Emergency Equipment Room, closed the door, pulled down her pants and fell. R6 had no injury. The analysis of the incident documents there was no lock on the door of the Emergency Equipment Room. The intervention documented to prevent reoccurrence is to install a lock on the door.

On 8/27/2015 at 3:00 PM, the Emergency Equipment Room was now locked and contained numerous supplies and a large, open and water filled hopper (flushing and cleansing toilet) with no lid.

The Incident Investigation, dated 11/23/2014 at 9:45 PM, documents R6 was found on the floor in the dining room and the safety alarm was not sounding. The analysis of the fall is documented that the string was too long to trigger the alarm to sound.

The Incident Investigation, dated 12/27/2014 at 3:00 PM, documents R6 grabbed the hand sanitizer that was left unattended on the medication cart and ingested a small amount from her hands into her mouth. The Poison Control Center and the Department was notified. R6's mouth was rinsed, and she was closely monitored for adverse effects.

The Incident Investigations for R6 documents 7 more falls, with no injury, while attempting to stand or transfer herself on 1/06/15 at 9:00 PM,

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3/10/15 at 7:45 PM, 3/14/15 at 3:15 PM, 4/24/15 at 7:30 PM, 5/23/15 at 2:55 PM, 6/02/2015 at 6:45 PM, and 7/05/2015 at 2:45 PM. The intervention after R6's fall on 7/05/2015 was to apply a self release belt while seated in the wheelchair, and to discontinue the chair pad sensor alarm.

R6's Care Plan, dated 8/11/2015, documents, in part, "(R6) is at risk for falls related to decreased balance, gait, diagnoses of Anemia, Osteoporosis with chronic low back pain. Each fall or incident is addressed in R6's Care Plan with interventions. An interventions documented, in part, in the Care Plan include, "Maintain a safe environment to room/facility to prevent injuries, well lit environment. Observe (R6) for any unassisted transfers/ambulation status. Remind to wait for assist and assist PRN (as needed)."

On 8/27/2015 at 9:52 AM, E7, Care Plan Nurse reported the facility has tried numerous interventions for R6 to prevent falls and injury and have recently restarted the use of the self release belt on 7/05/2015, that had been discontinued in 2014. E7 reported they have previously initiated a 15 minute observation schedule, but R6 is on no observation status at this time. There is no documentation in R6's clinical record or Incident Investigations to address that all of the falls and incidents occur on the evening shift for lack of supervision.

The Fall Prevention Protocol II, undated, documents, in part, "Initiate half-hour/hourly checks and/or placement of resident at nursing station, as needed." One to One or continuous observation for supervision to prevent falls or injury is not addressed in the Fall Protocol 1 or II.

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2. The POS for 8/2015 documents diagnoses for R2, in part, as Vascular Dementia, DJD, Generalized Weakness and Cancer of the Liver, Prostate and Colon. The MDS, dated 8/25/2015, documents R2 has no impairment with cognition, has unsteady balance from seated to standing, on and off the toilet and surface to surface transfers. The MDS documents R2 requires the assist of one staff for transfers and ambulation.

On 8/27/2015 at 9:37 AM, R2 stated, "I need to go to the bathroom," and turned on the call light. E8, Licensed Practical Nurse (LPN) responded to the call light. E8 watched R2 stand up from the bed and transfer himself to the wheelchair. R2 could not fully extend his legs, but kept his knees bent throughout the transfer, holding onto the arms of the wheelchair. E8 did not apply a gait belt to R2, but removed his indwelling urinary catheter from the bed frame and secured it under R2's wheelchair. E8 left R2's room. R2 then propelled himself to the B hall shower/bathroom using his upper extremities and left the door open. Both of R2's feet were on foot pedals. R2 locked his wheelchair, pulled the privacy curtain and transferred himself to the toilet. On 8/27/2015 at 9:52 AM, R2 transferred himself from the toilet to his wheelchair.

On 8/27/2015 at 11:25 AM, R2 propelled himself into the tub/shower room, leaving the door open. R2 locked the wheelchair which was positioned in front of the toilet, stood up slowly while holding onto the handrails next to the toilet and transferred himself. R2 pulled the privacy curtain halfway. At 11:28 AM, E9 and E10, Restorative Aides walked into the bathroom and asked R2 if he needed help. E9 was asked if R2 was

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supposed to take himself to the bathroom. E9 stated, "Yes, he can. He knows to ask for help. He toilets himself all the time. We check on him to see if he needs help. We walk around a lot, and if we see someone who may need extra help, we stop and check."

On 8/27/2015 at 11:32 AM, R2 stood himself up from the toilet with E10 observing, and transferred himself back to the toilet, holding onto the arm rests of the wheelchair. No gait belt was used for R2. R2 had his knees bent with a forward leaning posture during the transfer.

R2's Nurses Note, dated 6/28/2015 at 7:00 PM from E11, Registered Nurse (RN) documents, in part, "(Indwelling urinary) catheter tangled and was pulled out-bulb inflated. Hematuria from urethra. New catheter return of red colored urine. Sent to ER (Emergency Room). MD (Medical Doctor) called."

On 8/27/2015 at 4:00 PM, E10 was asked what happened on 6/28/2015 with R2. E10 stated, "He got himself up unassisted and transferred himself. The catheter bag tangled up and he tripped."

The Incident Investigation dated 8/23/2015 at 4:30 PM, documents, in part that R2 was getting up from bed unassisted and tripped over the urinary catheter drainage bag. R2 fell forward and hit his head on the closet door with his left knee hitting the floor. R2 sustained an abrasion to the right forehead and left knee. The intervention documented on the investigation is, "Extensive inservice with resident (R2) on proper placement of (catheter bag) and tubing to ensure safe transfer."

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R2's Care Plans, dated 5/26/2015 and 8/27/2015, document, in part, "At risk for falls related to general weakness, debility, anemia, HTN (Hypertension), use of antipsychotic meds (medication)." Interventions in the current Care Plan include; "Fall Protocol I, apply gait belt with one-two staff, staff to place call light string in hand when on toilet, and extensive inservice related to placement of (catheter) bag and tubing to ensure safety."

The facility Fall Prevention Protocol I, undated documents, in part, "Do not leave resident unattended if seated at bedside." The protocol fails to address leaving a resident unattended on the toilet.

3. R3's current face sheet documents diagnoses, in part, of Dementia with Behavioral Disturbances, Syncope and Collapse, Atrial Fibrillation, Alzheimer's Disease and Difficulty with Walking. The Fall Risk Assessments, dated 11/19/14, 1/25/15, and 5/26/15 assess R3 as a high risk for falls. The Fall Risk Assessments documents, in part, "If total score is 8 to 16: Initiate Fall Prevention Protocol II."

R3's MDS, dated 12/7/14, 3/7/15 and 6/7/15, documents R3 is moderately impaired with cognition, requires extensive assistance of 1 or more staff members for toileting, surface to surface transfers, and R3 has unstable balance while seated, standing, walking and only able to stabilize with staff assistance.

R3's "Investigation Report For Incidents," dated 11/19/14 at 4:45 AM documents R3 was found on the floor in room. R3 stated, "Getting my light."

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Interventions included applying a clip on R3's call light. No injury was documented.

R3's "Investigation Report For Incidents," dated 12/23/14 at 1:45 PM, documents R3 was found on the floor in the big bathroom after trying to transfer himself to the toilet. Interventions included frequent reminders to ask for assistance. No injury was documented.

R3's "Investigation Report For Incidents," dated 1/25/15 at 9:00 AM, documents R3 was found on the floor in his room. R3 stated, "I was trying to reach my light." Interventions included replacing the string for R3's light, as it was too short. R3 sustained no injury.

R3's "Investigation Report For Incidents," dated 3/22/15 at 10:00 AM, documents R3 was found on the floor in his room. R3 stated, "I slid out. Interventions included putting a personal alarm on the wheelchair as a reminder to call for help, and added a non-skid pad in the wheelchair.

R3's "Investigation Report For Incidents," dated 5/6/15 at 5:30 PM, documents R3 was found on the floor in the bathroom. The report documents R3 was transferring himself from the toilet back to the wheelchair and slid out onto floor on his buttocks. R3 sustained a 1.5 centimeter (cm) skin tear to his left elbow. Interventions include inservicing all Certified Nursing Assistants (CNA's) to not leave high risk residents alone in the restroom.

On 8/26/15 at 11:30 AM, E2, Director of Nursing (DON), stated, "If a resident is at risk for falls and if the resident has a chair pad alarm or personal alarm, they cannot be left alone while toileting."

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F 323	Continued From page 32 R3's Care Plan, dated 3/10/2015 documents, in part, "(R3) is at risk for falls related to decreased balance and atrial fibrillation contributes to fall potential. (R3) does not like to sit erect in his wheelchair, and is classified as a Fall Protocol #2." On 8/27/15 at 12:00 PM, E4, MDS Coordinator, stated, "The Fall Prevention Protocol II is a falling star program. If a resident is on the program, a star is put on the door jam to notify staff the resident is an increased fall risk." The facility "Fall Prevention Protocol I and II", undated, fails to address residents being left alone on the toilet.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		

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F 329	Continued From page 33 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to have a medically approved diagnosis, monitor the use of an antipsychotic medications, and follow physicians orders for a gradual dose reduction for 2 of 19 residents (R1, R4) reviewed for antipsychotic medications in the sample of 19. Findings include: 1. R1's current electronic medical diagnosis sheet documents R1 has diagnoses, in part, of Alzheimer's Disease, Nonpsychotic Mental Disorder and Major Depressive Disorder. R1's 8/2015 Physician's Order Sheet (POS) documents, in part, "Quetiapine tablet 25 milligrams sub for Seroquel 25 milligrams. Take one tablet by mouth daily." R1's August 2015 Behavior Tracking Sheets document R1 has behavior tracking in place for Resistive to care. On 8/25/15 at 8:55 AM, E2, Certified Nurses Aide (CNA), states, "(R1) does not have behaviors like hitting or anything sometimes she will get nervous."	F 329		

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On 8/25/2015 at 12:20 PM, E2, Director of Nurses (DON), stated, "(R1) does not have a proper diagnosis for the use of Seroquel. (R1) has delusions that should be one of her diagnosis. (R1) will think she is back home on her farm on the porch with her family watching the baby calves. (R1) should have behavior tracking in place for her delusions."

The Facility Policy Regarding Psychotropic Medications, dated 6/6/09, documents, in part, "I. Resident shall not be given unnecessary drugs. According to the Guidelines for Various Drugs, Section 300, Appendix F of the Illinois Nursing Home Rules, an unnecessary drug is any drug used:
A. In an excessive dose, including duplicative therapy;
B. For excessive duration;
C. Without adequate monitoring;
D. Without adequate indications for its use; or
E. In the presence of adverse consequences that indicate the drugs should be reduced or discontinued.
III. Residents shall not be given antipsychotic drugs unless antipsychotic drug therapy is necessary to treat specific or suspected conditions as diagnosed and documented in the clinical record or to rule out the possibility of one of the conditions listed in the guidelines for the Use of Various Drugs, Section 300, Appendix F, part G."

2. R4's POS, dated 02/15/14, documents R4 was admitted on 02/15/14, and add the diagnoses of Anxiety, Insomnia, and Agitation. The POS also documents Trazodone 50 mg by mouth every eight hours when ever needed related to increased anxiety. R4's Nurses Note and POS,

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dated 02/15/14 documents discontinue the when ever necessary Trazodone (the dosage she was taking at home), and start Trazodone 50 mg 1/2 tablets at bedtime.

R4's POS, dated 08/01/15, documents R4's diagnoses as Alzheimers Dementia, Benign Hypertension, Coronary Artery Disease, Change in Mental Status, Chronic Peptic Ulcer Disease, Closed Rib Fracture, Hip Pain, History of Fall, Post Cerebral Vascular Accident Hemiplegia, Scalp Laceration, Wrist Pain, Fall Risk, Left Foot Drop, and Appendectomy. R4's POS, dated 06/01/15 through 08/01/15, no longer documents diagnoses of anxiety, insomnia and agitation.

The Facility Contracted Pharmacy Form, dated 07/22/15, documents Z1, Physician, was notified that R4 has been on Trazodone 25 mg at bedtime since 02/15/14, and a Gradual Dose Reduction was recommended. Z1 signed the form, and documented on the form Trazodone 25 mg every other day at bedtime for two weeks then stop, and monitor (R4's) behavior.

R4's POS, dated 07/22/15, documents decrease Trazodone to 25 mg every other day for 2 weeks then stop and monitor behavior. This would mean that Trazodone should have been discontinued on 8/5/15.

R4's Medication Administration Record Form (MAR), dated 07/01/15 to 07/31/15 documents R4 was given Trazodone 50 mg 1/2 tablet 25 mg by mouth every night at bedtime from 07/22/15 to 07/29/15. R4's MARS dated 07/29/15 through 08/31/15 documents R4 was receiving Trazodone 25 mg every other day at bedtime from 07/29/15 through 08/25/15.

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F 329	Continued From page 36 On 08/26/15 at 8:30 AM, E2, Director of Nursing (DON) stated "When we get a pharmacy recommendation, we give it to (Z1), and she writes the order, and takes it with her. We didn't get the order for the reduction back from (Z1) until 07/29/15, when the order was noted by the nurse." This would mean that the Trazodone should have been discontinued on 8/12/15. The undated Consulting Pharmacy Policy entitled Prescriber Medication Orders documents (in part) following the receipt and documentation of a change in medication order. The nurse is to immediately enter the information on the patients medication administration record and physician order sheet. The medication orders, for which changes have been made must be completely rewritten in the (MAR) as a new order. The previous order is to be discontinued.	F 329		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide sufficient qualified nursing staff on multiple days to allow for adequate nursing services. This has the potential to affect all of the 91 residents living in the facility. Findings include: 1. The staffing schedule received on 8/24/15 documents there was no Registered Nurse (RN) coverage for the dates of 8/1/15 and 8/2/15. On 8/27 /15 at 11:00 AM, E2, Director of Nursing, (DON) stated that she was aware that proper nursing coverage was not provided on 8/1/15 and 8/2/15. E2 then stated she had hired a new RN for nights but she was in training at that time. E2 also stated the Facility hasn't had consistent coverage for the past 2-3 months. On 8/31/15 at 10:30 AM, E1, Administrator, stated that the Facility did not have a written staffing policy, but follows the state staffing standard. 2. The Resident Census and Conditions of Residents, CMS 672, dated 8/24/15 documents that the Facility has 91 residents living in the facility.	F 354		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145515	A. BUILDING _____ B. WING _____	08/31/2015

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F 425	Continued From page 38 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to send a new order to pharmacy in a timely manner and stop a medication as ordered for 1 of 19 residents (R4) reviewed for physician orders in the sample of 19. Findings Include: R4's Physician Order Sheet (POS), dated 02/15/14, documents R4 was admitted on 02/15/14. The POS also documents start Trazodone 50 milligram (mg) 1/2 tablet at bedtime. The same POS documents add the diagnoses anxiety, agitation and insomnia. R4's Physicians Order Sheet (POS) dated 08/01/15 documents R4's diagnosis is Alzheimers Dementia, R4's POS, dated 06/01/15 through 08/01/15, no longer documents diagnoses of	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 39	F 425		

anxiety, insomnia and agitation.

The Facility Contracted Pharmacy Form, dated 07/22/15, documents Z1, Physician, was notified that R4 has been on Trazodone 25 mg at bedtime (HS), since 02/15/14, and a Gradual Dose Reduction was recommended. Z1 signed the form, and documented on the form Trazodone 25 mg every other day at bedtime for two weeks then stop, and monitor (R4's) behavior.

R4's POS, dated 07/22/15, documents decrease Trazodone to 25 mg every other day for 2 weeks then stop and monitor (R4's) behavior. This means the Trazodone should have been discontinued on 8/5/15

R4's Medication Administration Record Form (MAR), dated 07/01/15 to 07/31/15, documents R4 was given Trazodone 50 mg 1/2 tablet 25 mg by mouth every night at bedtime from 07/22/15 to 07/29/15. R4's MAR, dated 07/29/15 through 08/31/15, documents R4 was receiving Trazodone 25 mg every other day at bedtime from 07/29/15 through 08/25/15. The 08/01/15 MAR also documented stop the Trazodone after 14 days.

On 08/28/15 at 9:15 AM, Z2, Pharmacy Consultant, stated "We received the new order for Trazodone on 07/29/15, but did not send out the medication, because the facility already had a supply of Trazodone. The August POS that we sent over stated stop the Trazodone on 08/12/15. We didn't know the facility continued to give the Trazodone pass the 08/12 date."

08/26/15 at 8:30 AM E2 Director of Nursing stated "When we get a pharmacy

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F 425	Continued From page 40	F 425		

recommendation, we give it to (Z1), and she writes the order, and takes it with her. We didn't get the order for the reduction back from (Z1) until 07/29/15, when the order was noted by the nurse.

The Facility Policy entitled Consulting Services documents "The consultant pharmacist shall review the resident's drug regimen and make the appropriate recommendations to improve the overall care within the facility."

The undated Consulting Pharmacy Policy entitled Prescriber Medication Orders documents (in part), "following the receipt and documentation of a change in medication order. The nurse is to immediately enter the information on the patients medication administration record and physician order sheet. The medication orders, for which changes have been made must be completely rewritten in the (MAR) as a new order. The previous order is to be discontinued."