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	146010	A. BUILDING _____ B. WING _____	C 06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTIAC HEALTHCARE AND REHAB	**300 WEST LOWELL PONTIAC, IL 61764**

(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 000	INITIAL COMMENTS Complaint # 1663177/IL86120 A partial extended survey 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 interview and record review the facility failed to identify and immediately report to the Abuse Prohibition Coordinator(E1) allegations of mental abuse for R1, R3, R7 and R8. The facility failed to ensure the protection of the residents from the potential of further abuse by allowing the alleged perpetrators to continue to provide direct care to residents. These failures have the potential to affect all 69 residents residing in the facility. Findings include: 1. The undated electronic Current Diagnosis Sheet documents R3 has a diagnosis of Alzheimer's Disease. The MDS (Minimum Data Set) dated 6/4/16 documents that R3 has severe cognitive impairment and behaviors. The MDS dated 6/6/16 documents R1 has a diagnosis of Dementia with Behavioral Disturbance. The MDS documents that R1 has severe cognitive impairment. On 6/14/16 at 1:05pm E6(Certified Nurse Aide/CNA) stated that E7(CNA) and E8(Licensed Practical Nurse/LPN) were transferring R3 from the toilet to the chair. When, E7 and E8 stood R3, his (R3) hand went between E7's legs and E7 said "...that's my vagina (expletive)." E6 stated this happened on the midnight shift, but didn't	F 225		

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PONTIAC HEALTHCARE AND REHAB	**300 WEST LOWELL PONTIAC, IL 61764**

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F 225	Continued From page 2	F 225		

remember the date. E6 stated there was another incident with E7 that involved R1. E6 stated that E7 and herself (E6) were trying to change R1's shirt because it was wet and R1 was fighting and telling them to leave him alone. E6 stated that E7 told R1 to "...stop being a (expletive)." E6 stated she didn't remember if the incidents with R3 and R1 occurred on the same day, but they were separate incidents. E6 stated she doesn't think anyone was in the room with herself and E7 when the incident with R1 occurred. E6 stated she did not immediately report the incidents involving R3 and R1. E6 stated, "I didn't know what to do-I talked (about it) at home how to handle it." E6 stated "I know it should have been (reported)-that's a scary thing. I talked to (E2, DON [Director of Nursing]) and told her of the situation with (E7) involving (R3) and (R1)." E6 stated, "I told (E2) that I didn't want to work with (E7) and she stopped putting me over on the unit with (E7)." E6 stated she told E2 to report the incidents involving R3 and R1.

2. On 6/14/16 at 1:50pm E2, DON stated she received a call from E6. E2 stated E6 told her that E6 overheard E7 and E8 calling R7 a name. E2 did not remember the date when she talked to E6. E2 stated she "asked around to see if anyone noticed inappropriate behavior," but did not document what she did. E2 stated she did not report the allegation to E1, Administrator (Abuse Prohibition Coordinator), did not do a complete investigation and did not remove E7 and E8 from work. E2 stated she then received a phone call from E13, RN (Registered Nurse) that E6 was still talking about the name calling incident, but no names were mentioned to E13. E2 stated she then called E6 and E6 told a "different story" but E2 does not recall the story. E2 stated she

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thought E6 was talking about R7 when she talked to E13. E2 could not remember anything about the second call to E6, except "I (E2) thought she was talking about (R7).." E2 stated she then notified E1 about the allegation of staff calling R7 names. E2 stated she does not know how much time was between the two calls, the first one with E6 and the call when E13 called her. E2 stated that E7 floats through out the facility providing care to all residents.

3. On 6/14/16 at 2:45pm E1, Administrator stated that E2 told her on 5/20/16 at 7:00am that E6 alleged that one of the CNA's (E7) called R7 names. E1 stated she immediately suspended E7 and started the investigation. E1 stated she talked to E6 during the investigation and that's when she learned that it wasn't R7 that was called a name, but R1 and R3. E1 stated that E6 was specific about what happened. On 6/15/16 at 2:00pm E1 verified that E2 only reported E7 and didn't mention E8.

The Electronic Time Sheets dated 5/1-5/20/16 documents E7, CNA worked the 10:00pm to 6:00am shift on 5/3-5/7/16, 5/10-5/14/16 and 5/17-5/19/16. E7 did not work 5/20/16.

The Electronic Time Sheet dated 5/1-5/20/16 documents that E8(LPN) worked 5/2-5/7/16, 5/10-5/5/12/15 and 5/15-5/19/16.

4. The MDS dated 5/31/16 documents that R8 has a diagnoses of Cerebrovascular Accident with Hemiplegia. The MDS documents that R8 has moderate cognitive impairment, requires extensive assist of one with toileting and has gastrostomy tube feedings.

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F 225	Continued From page 4 On 6/14/16 at 9:35am E10(CNA) stated when R8 called to go to the bathroom, E9(CNA) told R8 to wet in her briefs and then pushed on her bladder. E10 stated it happened on the last night (5/29) he worked at the facility. E10(CNA) stated he reported the incident with R8 and E9 to E2(DON) in an email that he sent her with his resignation from the facility. On 6/14/16 at 2:10pm E2 stated she got an e-mail from E10 saying that he was resigning, and was upset about residents getting up early, but didn't remember anything else. E2 stated she no longer has the e-mail. When asked if she was aware of E9 telling R8 to wet her briefs when she asked to go to the bathroom and then pushing on R8's bladder, E2 stated "this is the first time I've heard of that." E2 stated there was nothing in E10's e-mail about E9 or R8. E2 stated the incident with E9 and R8 should have been reported. E2 verified that E9 works throughout the facility providing care to residents. On 6/14/16 at 3:00pm the allegation involving R8 and E9 was given to E1, Administrator. E1 verified that she was unaware of this allegation and would immediately suspend E9. On 6/14/16 at 4:00pm E18, Human Resources verified that E10's last night to work was 5/29/16. The electronic Time Record dated 5/29-6/14/16 documents E9, CNA worked 10:00pm to 6:00am on 5/29-5/31/16, 6/2-6/5/16 and 6/7-6/9/16. The Facility Data Sheet dated 6/13/16 documents that 69 residents reside in the facility.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

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F 226 SS=F	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to operationalize the Abuse Prohibition Policy in the areas of training, reporting and protection of residents from the potential of further abuse. The facility failed to ensure administration and employees were trained to immediately report allegations of abuse to the Abuse Prohibition Coordinator(E1) resulting in allegations of mental/verbal abuse not being reported immediately. The facility failed to ensure the protection of the residents from the potential of further abuse by allowing the alleged perpetrators to continue to provide direct care to residents. These failures have the potential to affect all 69 residents residing in the facility. Findings include: The facility Abuse Prevention Program dated 7/23/15 documents the following: "...the facility will cover the following topics:....What constitutes abuse, neglect.....; and how to distinguish...willful abuse from insensitive staff actions....On an annual basis, staff will receive a review of the above topics...Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about or suspect to the	F 226		

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administrator, or an immediate supervisor who must then immediately report it to the administrator...Such reports may be made without fear of retaliation..Supervisors shall immediately inform the administrator.....Employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately until results of the investigation have been reviewed by the administrator...."

1. On 6/14/16 at 1:05pm E6, CNA(Certified Nurse Aide/CNA) stated that E7(CNA) and E8(Licensed Practical Nurse/LPN) were transferring R3 from the toilet to the chair. E6 stated when they stood R3, his (R3) hand went between E7's legs and E7 said, "...that's "my vagina (expletive)." E6 stated that E7 and herself (E6) were trying to change R1's shirt and R1 was fighting and telling them to leave him alone. E6 stated that E7 told R1 to "...stop being a (expletive)." E6 stated the incidents with R3 and R1 occurred on the same day, but they were separate incidents. E6 stated she did not immediately report the incidents involving R3 and R1 as E6 thought about it overnight before reporting it.

2. On 6/14/16 at 1:50pm E2, DON stated E6 told her that she overheard E7 and E8 calling R7 a name. E2 stated she "asked around to see if anyone noticed inappropriate behavior," but did not document what she did. E2 stated she did not report the allegation to E1, Administrator (Abuse Prohibition Coordinator), did not do a complete investigation and did not remove E7 and E8 from work.

3. On 6/14/16 at 1:50pm E2 stated, she received a phone call from E13(Registered Nurse/RN) that

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F 226	Continued From page 7	F 226		

E6 was still talking about the name calling incident, but no names were mentioned to E13. E2 stated she thought E6 was talking about R7 when she talked to E13 and E6 about the name calling. E2 stated she then notified E1 about the allegation of staff calling R7 names. E2 stated that E7 floats through out the facility providing care to residents.

On 6/14/16 at 2:45pm E1, Administrator stated that E2 told her on 5/20/16 at 7:00am that E6 alleged that one of the CNA's (E7) called R7 names. E1 stated she immediately suspended E7 and started the investigation. E1 stated she talked to E6 during the investigation and that's when she learned that it wasn't R7 that was called a name, but R1 and R3. E1 stated that E6 was specific about what happened. On 6/15/16 at 2:00pm, E1 verified that E2 only reported E7 and didn't mention E8.

4. On 6/14/16 at 9:35am E10(CNA) stated when R8 called to go to the bathroom, E9(CNA) told R8 to wet in her briefs and then pushed on her bladder. E10 stated it happened on the last night (5/29) he worked at the facility. E2 stated he reported the incident with R8 and E9 to E2, DON in an email.

On 6/14/16 at 2:10pm E2 stated she got an e-mail from E10 saying that he was resigning. E2 stated E10 didn't report anything to her about the incident involving R8 and E9. E2 verified that E9 works throughout the facility providing care to residents.

5. On 6/13/16 at 9:45am E1(Administrator) verified that she is the Abuse Prohibition

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F 226	Continued From page 8 Coordinator. On 6/14/16 at 3:35pm E20(RN) stated if she had an allegation of abuse she would probably talk to E1 and E2. E20 stated she would "probably wait til morning" to notify them. E20 stated if E1 and E2 didn't answer their phone she would probably text them. When asked how she would protect the residents from further possible abuse, E20 stated she would move the employee to a different unit. E20 works 10:00pm to 6:00am. On 6/15/16 at 11:55am E13(RN) stated that E2(DON) is the Abuse Prevention Coordinator. E13 works 10:00pm to 6:00am. On 6/15/16 at 2:05pm E15(RN) stated he would notify E2(DON) if there was an allegation of abuse. E15 was unable to identify who was the Abuse Prohibition Coordinator. E15 works 2:00pm to 10:00pm. On 6/15/16 at 6:20am E12(CNA) was unable to identify who was the Abuse Prohibition Coordinator. On 6/15/16 at 5:30am E11(CNA) was unable to identify who was the Abuse Prohibition Coordinator. The Facility Data Sheet dated 6/13/16 documents that 69 residents reside in the facility.	F 226		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 9 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to toilet one of one resident (R8) reviewed for toileting, on the sample of 13. Findings include: The undated electronic diagnosis list documents that R8 has a diagnosis of Cerebrovascular Accident with Hemiplegia. The Minimum Data Set (MDS) dated 5/31/16 documents that R8 has moderate cognitive impairment and requires extensive assist with transfer and toileting. The MDS documents that R8 receives feedings through a gastrostomy tube and is frequently incontinent of bladder. The Care Plan dated 5/27/16 documents that R8 requires extensive assist with toileting and is on a restorative toileting program. the Care Plan states to ensure continence to take R8 to the toilet as soon as possible when R8 states she needs to toilet. On 6/14/16 at 9:35am E10(Certified Nurse Aide/CNA) stated when R8 called to go to the bathroom, E9, CNA told R8 to wet in her briefs and then pushed on her bladder. E2 stated he thought E9 just didn't want to get R8 up. On 6/15/16 at 11:35am E9(CNA) stated that he did tell R8 to "wet her brief" when she asked to go to the bathroom. E9 stated he pushed on R8's bladder "lightly" to help her urinate. E9 stated that R8 is "hard" to get up during the night because her gastrostomy tube is hooked up and running.	F 312		

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F 312	Continued From page 10 E9 stated he didn't ask the nurse to unhook R8's gastrostomy tube because she was over on the other hall in the facility. E9 stated R8's brace, shoes and socks need to be put on and "90% of the time she (R8) won't do anything."	F 312		
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 and interview the facility failed to ensure the surface of an assistive device and furniture was maintained in good condition and free from sharp edges for three of six residents (R1, R3, and R6), reviewed for potential environmental hazards, in a sample of 13. Findings include: 1. On 6/13/16 at 9:00am and at 2:40pm a reclining chair with a torn leg rest with the wood exposed across the width of the leg rest. The exposed wood on the leg rest was located in the area where the calves of the legs would rest. The reclining chair was located in the hall directly across from R3's room. At this same time a wheel chair with the vinyl back was cracked, peeling and had sharp edges. The wheelchair was located directly across from R3's room in the hall.	F 323		

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F 323	Continued From page 11 On 6/13/16 at 10:10am, E3(Certified Nursing Assistant/CNA), verified that the reclining chair with the torn foot rest and the wheel chair with the cracked back was used by R3. On 6/13/16 at 2:35pm, E4(Certified Nursing Assistant/CNA), verified that the reclining chair with the torn and exposed foot rest was used by R3. E4 also verified that the wheel chair with the cracked and peeling back was used by R3. E4 stated she notified E19(Maintenance) was notified of the tear in the foot rest of the R3's reclining chair awhile ago, but was unable to remember when. 2. On 6/13/16 at 2:15pm, R1's room contained a high back chair with a torn bottom front, with rough edges and the wood showing. 3. On 6/13/16 at 2:30pm, R6's night stand in R6's room was missing the top drawer covering and handle, exposed jagged hard plastic was noted. On 6/14/16 at 10:00am, E1(Administrator), verified that any chairs that have torn or exposed surfaces should be taken out of service. E1 also stated that a dresser missing a drawer missing the front cover should be repaired or taken out of service.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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PONTIAC HEALTHCARE AND REHAB	**300 WEST LOWELL PONTIAC, IL 61764**

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F 431	Continued From page 12 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the medication cart was locked and inaccessible to residents, for three of three residents (R9,R10,R11) reviewed for medications in a sample of 13. Findings include:	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146010	A. BUILDING _____ B. WING _____	C 06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 13 The facility's Storage of Medications Policy, dated 6/15/1998, documents "All medications will be safe and properly stored...All medications for all residents shall be stored in or near the nurse's station, in a locked cabinet, a locked medication room, or in a locked secured medication cart....." On 6/15/16 at 7:30am, west wing unlocked medication cart was outside of a R10's room. E14(Registered Nurse/RN), did not have visual access to the unlocked medication cart. E14 was observed exiting from a room three doors down the hall from the medication cart. R11's medications were in a medication cup on top of the medication cart. R11's medications were Omeprazole (Proton Pump Inhibitor) 20mg (milligrams), Carafate (antacid) one gram, Furosemide (Diuretic) 40mg, Bupropion (antianxiety) 150mg, Lisinopril (Ace Inhibitor) 2.5mg, Asprin (Antiplatelet) 81mg. There were also eight bottles of stock medications on top of the medication cart, which consisted of Cranberry 425mg tablets, Os-cal 500mg, Multivitamin with minerals, multiunit (all supplements), Tylenol 325mg, bottle of Mirlax powder, Docusate Sodium 100mg, Asprin 81mg. R10 was pacing from his room into the hall and back into the room. R10 did this several times. The unlocked medication cart with unattended medications on top, was in front of R11's room. The top drawer of the unlocked medication cart contained multiple vials of diabetic insulin's, insulin syringes, eye drops and more stock medications. The second drawer contained 113 personal medications cards. The third drawer contained 95 cards of personal medication cards. The fourth drawer contained 182 personal medication cards. All three drawers contained medications such as	F 431		

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F 431	Continued From page 14 coumadin, antipsycotics, antihypertensives, antidepressants and anticonvulsant's. On 6/15/16 at 7:35am, E14 verified that the medication cart was left unlocked and unattended. E14 stated that E14 should have put the medications away and locked the cart prior to walking away from it. On 6/15/16 at 10:00am, E1(Administrator), verified that R9 is the only confused ambulatory resident residing on the unit. On 6/15/16 at 12:25pm, E1 verified that the medications on top of the cart should have been put away and the cart should have been locked before the staff (E14) walked away from the cart. On 6/15/16 at 2:35pm, E2(Director of Nursing/DON), verified that the medication carts should be locked when staff does not have visual access to it. E2 also stated that the medications on top of the medication cart should have been put away, before E14 walked away from it.	F 431		