STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. BUILDING ______ B. WING ______	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAR KA NURSING HOME	**201 SOUTH 10TH STREET MASCOUTAH, IL 62258**

(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 Investigation #1641125/ IL83735	F 000		
F 225 SS=D	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 certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		3/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/17/2016

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F 225	Continued From page 1	F 225		

appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the Facility failed to report a incident concerning a resident-to-resident altercation to the Illinois Department of Public Health (IDPH), for 2 of 2 (R1, R2) residents who were involved in a resident-to-resident altercation in the sample of 7.

Findings include:

The Facility "Investigation Summary", dated 10/25/15, documents that "At approximately 2:05 PM, an altercation occurred between (R1) and (R2). Incident was unwitnessed by staff. (R1) ambulated into (R2's) room and (R1) was in (R2's) closet, pulling items out of the closet. (R2) told (R1) to stop it and get out of the room.
(R1) then struck (R2) in the right eye area, with his closed fist. (R2) reported to nurse (E4), that (R1) hit him and he hit (R1) back. (R2) than said that (R1) hit him 5 more times and then (R1) fell on the floor.
(R1) told nurse (E5) that he was in the closet and (R2) swung at him, and (R1) stopped him but then (R1) hit (R2). (R1) also stated that he is tired of being threatened and thinking he's a pushover because he is not a pushover. Nurse noted that a bruise was forming on (R1's) 4th and 5th knuckles.
Certified Nurses Aide (CNA), E6, heard (R2) calling for help and went down hall. (R1) was holding his roommate's walker, gritting his teeth, visibly angry and agitated. E6 noted (R2) in his room with blood on is cheek. (R1's) roommate

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F 225	Continued From page 2	F 225		

had not seen what occurred; he came out of the room at the sound of (R2) calling for help.
In summation, (R2) was attempting to stop (R1) from rummaging in his closet, and (R1) struck (R2) in the right eye. (R1) is fully ambulatory, with good upper body strength; however, he is also very demented, having scored a 0 out of 30 on the St. Louis University Mental Status (SLUMS) Examination. He can recognize his wife consistently, but required moderate to total assistance in performing Activities of Daily Living (ADL), such as bathing, dressing and requires close supervision and monitoring for personal safety as attempts often to exit Facility doors.
(R2) was transported to the emergency room for evaluation - CT Scan complete with no acute findings, and he was returned that same evening to the nursing home.
(R1) was issued an emergency discharge and was transported to the hospital from which he was relocated to another Facility.

R1's Minimum Data Set (MDS), dated 9/21/15, documents a Brief Interview of Mental Status (BIMS) score of 0, which means he is severely cognitively impaired. R1's current plan of care documents behaviors of wandering into other residents rooms, getting agitated with staff and peers, and attempting to eat off of other residents plates

R2's Minimum Data Set (MDS), dated 12/27/15, documents a BIMS of 15, which means he is cognitively intact. R2's current plan of care documents that he has delusions due to a diagnosis of Schizophrenia.

E5, Licensed Practical Nurse, signed a statement, dated 10/25/15, which was attached to

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F 225	Continued From page 3 the "Investigation Summary". This statement documents "Bruising noted to (R2's) right eye and a 1.1 centimeter (cm) skin tear on the the lower part of (R2's) right eye. (R2) remains in his room and (R1) is on one-to-one supervision at the nurses station. Police, Administrator, physician, IDPH notified." E5, LPN, stated on 3/8/16, at 12:30 PM, that she called the IDPH Hotline phone number which is utilized to file complaints when the incident between R1 and R2 occurred. E5 said that neither she, nor the other nurse on duty, R4, filled out or faxed any paperwork concerning the incident to the Department. E2, Director of Nursing (DON) and E3, Assistant Director of Nursing (ADON), stated on 3/8/16 at 12:25 PM that neither one of them faxed a report to the Department concerning the incident between R1 and R2. Both E2 and E3 said that they assumed that E1. Administrator, would notify the Department concerning the incident. E1, Administrator, stated on 3/8/16 at 12:20 PM, that "We just called the 1-800 Hotline number to report the incident. I never faxed in a report or a follow-up report. I know that I'm supposed to do that."	F 225		
F 226 SS=D	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		3/18/16

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Facility failed to operationalize their policy for reporting an incident of resident-to-resident abuse to the Department for 2 of 2 (R1, R2) residents involved in a resident-to-resident abuse altercation in the sample of 7. Findings include: The Facility "Investigation Summary", dated 10/25/15, documents that "At approximately 2:05 PM, an altercation occurred between (R1) and (R2). Incident was unwitnessed by staff. (R1) ambulated into (R2's) room and (R1) was in (R2's) closet, pulling items out of the closet. (R1) told (R2) to stop it and get out of the room. (R1) then struck (R2) in the right eye area, with his closed fist. (R2) reported to nurse (E4), that (R1) hit him and he hit (R1) back. (R2) than said that (R1) hit him 5 more times and then (R1) fell on the floor." E5, Licensed Practical Nurse, signed a statement, dated 10/25/15, which was attached to the "Investigation Summary". This statement documents "(R2) remains in his room and (R1) is on one-to-one supervision at the nurses station. Police, Administrator, physician, IDPH (Illinois Department of Public Health) notified." E5, LPN, stated on 3/8/16, at 12:30 PM, that she called the IDPH Hotline phone number which is utilized to file complaints when the incident between R1 and R2 occurred. E5 said that neither she, nor the other nurse on duty, E4, filled out or faxed any paperwork concerning the	F 226		

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F 226	Continued From page 5	F 226		

incident to the Department.

E2, Director of Nursing (DON) and E3, Assistant Director of Nursing (ADON), stated on 3/8/16 at 12:25 PM that neither one of them faxed a report to the Department concerning the incident between R1 and R2. Both E2 and E3 said that they assumed that E1, Administrator, would notify the Department concerning the incident.

E1, Administrator, stated on 3/8/16 at 12:20 PM, that "We just called the 1-800 Hotline number to report the incident. I never faxed in an initial report or a follow-up report. I know that I'm supposed to do that."

The Facility "Abuse Prohibition Policy", dated August 2015, documents "Reporting: The Facility will ensure that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported immediately to the Administrator. All allegations will be reported to all officials in accordance with state law and federal regulations. Initial report will be filed to state certification agency IMMEDIATELY without delay, with follow-up and findings within five working days of incident, and alleged violation is verified appropriate, corrective action will be taken.