STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145471	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEBELLO HEALTHCARE CENTER	1599 KEOKUK STREET HAMILTON, IL 62341

(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 Original complaint investigation for 1324515/IL66337 Federal Oversight and Support Survey 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	F 225		

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

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F 225	Continued From page 1 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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately report allegations of abuse to the state agency for one resident (R6) in the supplemental sample; and the facility failed to investigate a verbal threat of violence against the facility, report the incident to the state agency, and notify local law enforcement of that threat. This failure has the potential to affect all 78 residents residing at the facility. Findings include: A policy titled Abuse and Neglect Prohibition dated 6/2013 states, "Any observation of abuse, neglect, or mistreatment must be immediately reported to the Administrator and/or Director of Nursing....The facility will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state law... The facility will report such allegation to the state, in accordance with state regulation....The facility will make referral to the appropriate state agencies as necessary, to ensure the protection of the resident or resident's property... In accordance with the Elder Justice Act, the facility will report to law enforcement agencies and to the state agency any reasonable suspicion of a crime against any individual who is	F 225		

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F 225	Continued From page 2 a resident of, or receives care from the facility...	F 225		

On 11/07/13 at 10:15 a.m., E1 (Administrator) stated Z3 (R1's family member) was asked to leave the facility (on 10/17/13) due to inappropriate behavior. E1 reported Z3 was upset and, "Yelling that he was going to take the roof off." E1 indicated E1 was not present at the time of the incident, but Z3 was walked out of the facility (by E5 Social Services) because Z3 was "upsetting everyone." When asked if E1 notified local law enforcement of Z3's threat, E1 stated, "No. Should I have?"

Social Progress Notes dated 10/17/13 and written by E5 (Social Services) state, "...(E13 LPN - Licensed Practical Nurse)...said when (Z3) was leaving (Z3) stated, 'No one will tell (Z3) when (Z3) can visit (R1). I'll blow the f-----g roof off this building!' This behavior was reported to (E1 Administrator)..."

On 11/07/13 at 10:15 a.m., regarding 10/17/13 and Z3's actions, E5 (Social Service) stated, "...I saw (Z3) in the dining room and I discussed (Z3) recalling our conversations about not visiting during meal times. (Z3) said (Z3) wanted to speak with (E16 - Business Manager). I said (E16) wasn't here and (Z3) said he'd come back later and left. The nurse (E13 LPN - Licensed Practical Nurse) told me afterwards what (Z3) said (to E13 LPN as Z3 was leaving) so I charted it..."

On 11/14/13 at 11:20 a.m., regarding Z3's actions on 10/17/13, E13 (LPN) stated, "... (Z3) came walking by and I said hi. (Z3) leaned into me and said, 'I tell you if they don't allow me to see (R1)

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F 225	Continued From page 3	F 225		

when I want to see (R1) I'm going to blow the f-----g roof off the place.' I asked the other nurse who (Z3) was and then I went and told (E5 Social Services) about it. (Z3) kept walking and left the facility. I don't remember what time it was. I probably should have went to see (E1 Administrator) right away but I just went to the first office door open and that was (E5 Social Services)... I don't think anyone else heard it at all..." E13 (LPN) indicated (E13) was aware the facility abuse policy directs staff to report incidents like this to E1 (Administrator).

A policy title Elder Justice dated 10/2013 states, "...Covered individuals are required to report to local law enforcement agencies and to the state agency any reasonable suspicions of a crime against any individual who is a resident of, or receives care from the facility... reasonable suspicion of a crime include but are not limited to the following... Assault...If the event that caused the suspicion result in serious bodily injury, the the covered individual must report the suspicion immediately, but no later than two hours after forming the suspicion. If the event that caused the suspicion does not result in serious bodily injury, then the covered individual shall report the suspicion no later than twenty-four hours after forming the suspicion...The facility Administrator is required to report suspicion of a crime to law enforcement and to the state agency within the timeframe set forth..."

On 11/07/13 at 4:05 p.m., when asked if Z3's threat on 10/17/13 was reported to law enforcement and investigated, E1 (Administrator) stated, "I would have if I thought (Z3) was serious. Maybe I should have." E1 also confirmed at that time, that the incident was not

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F 225	Continued From page 4 reported to the state agency either. A Facility Data Sheet dated 11/07/13 completed by E12 (Health Information Coordinator) indicates the current resident census at the facility is 78.	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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately report allegations of abuse to the state agency for one resident (R6) in the supplemental sample and failed to investigate a verbal threat of violence against the facility, report the incident to the state agency, and notify local law enforcement of that threat, as required by facility policies. This failure has the potential to affect all 78 residents residing at the facility. Findings include: A policy titled Abuse and Neglect Prohibition and dated 6/2013 states, "...Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the Administrator and/or Director of Nursing...The facility will report all allegations and substantiated occurrences of abuse, neglect, injuries of unknown origin, and misappropriation of property	F 226		

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F 226	Continued From page 5	F 226		

to the state agency and law enforcement officials as designated by state law...In accordance with the Elder Justice Act, the facility will report to law enforcement agencies and to the state agency any reasonable suspicion of a crime against any individual who is a resident of, or receives care from the facility..."

The policy titled Abuse and Neglect Prohibition dated 6/2013 states, "...Any observations or allegation of abuse, neglect, or mistreatment must be immediately reported to the Administrator and/or Director of Nursing...The facility will report all allegations and substantiated occurrences of abuse, neglect, injuries of unknown origin, and misappropriation of property to the state agency and law enforcement officials as designated by state law..."
The same policy states, "... The facility will conduct an investigation of any alleged abuse/neglect... The facility will protect residents from harm during the investigation. The facility will make referrals to the appropriate state agencies as necessary, to ensure the protection of the resident or the resident's property..."

Facility policy, titled "Elder Justice" and dated 10/2013, states, "...Covered individuals are required to report to local law enforcement agencies and to the state agency any reasonable suspicions of a crime against any individual who is a resident of, or receives care from the facility... reasonable suspicion of a crime include but are not limited to the following... Assault...If the event that caused the suspicion result in serious bodily injury, the covered individual must report the suspicion immediately, but no later than two hours after forming the suspicion. If the event that caused the suspicion does not result in

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F 226	Continued From page 6	F 226		

serious bodily injury, then the covered individual shall report the suspicion no later than twenty-four hours after forming the suspicion...The facility Administrator is required to report suspicion of a crime to law enforcement and to the state agency within the timeframe set forth..."

1. On 11/07/13 at 10:15 a.m., E1 (Administrator) stated Z3 (R1's family member) was asked to leave the facility (on 10/17/13) due to inappropriate behavior. E1 reported Z3 was upset and "Yelling that he was going to take the roof off". E1 indicated E1 was not present during the incident but that Z3 was walked out of the facility (by E5 Social Services) because Z3 was "upsetting everyone". When asked if E1 notified local law enforcement of Z3's threat, E1 stated, "No. Should I have?"

Social Progress Notes dated 10/17/13 state, "... (E13 LPN - Licensed Practical Nurse)...said when (Z3) was leaving (Z3) stated, 'No one will tell (Z3) when (Z3) can visit (R1). I'll blow the f-----g roof off this building!'. This behavior was reported to (E1 Administrator)..." On 11/07/13 at 10:15 a.m., regarding 10/17/13 incident and Z3's actions, E5 (Social Service) stated, "...I saw (Z3) in the dining room and I discussed (Z3) recalling our conversations about not visiting during meal times. (Z3) said (Z3) wanted to speak with (E16 - Business Manager). I said (E16) wasn't here and (Z3) said he'd come back later and left. The nurse (E13 LPN - Licensed Practical Nurse) told me afterwards what (Z3) said so I charted it..."

On 11/14/13 at 11:20 a.m., regarding Z3's actions on 10/17/13, E13 (LPN) stated, "... (Z3) came walking by and I said hi. (Z3) leaned into me and said, 'I tell you if they don't allow me to see (R1)

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F 226	Continued From page 7 when I want to see (R1) I'm going to blow the f-----g roof off the place.' I asked the other nurse who (Z3) was and then I went and told (E5 Social Services) about it. (Z3) kept walking and left the facility. I don't remember what time it was. I probably should have went to see (E1 Administrator) right away but I just went to the first office door open and that was (E5 Social Services)... I don't think anyone else heard it at all..." E13 (LPN) indicated (E13) was aware the facility abuse policy directs staff to report incidents like this to E1 (Administrator). On 11/07/13 at 4:05 p.m., when asked if Z3's threat on 10/17/13 was reported to law enforcement and investigated, E1 (Administrator) stated, "I would have if I thought (Z3) was serious. Maybe I should have." E1 also confirmed at that time, that the incident was not reported to the state agency either. A Facility Data Sheet dated 11/07/13 completed by E12 (Health Information Coordinator) indicates the current resident census at the facility is 78.	F 226		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F 356		

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F 356	Continued From page 8 vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to publicly post statutorily-mandated staffing data regarding the number of licensed and unlicensed nursing staff directly responsible for resident care for each daily shift. This has the potential to affect all 78 residents residing at the facility. Findings include: Daily Staffing Postings, dated 11/07/13 through 11/14/13, document the facility is not including the total number of actual hours worked per shift for licensed and unlicensed staff providing direct resident care.	F 356		

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F 356	Continued From page 9 On 11/14/13 at 10:00 a.m., E2 (DON - Director of Nursing) stated that E2 prepares and posts the Daily Staffing Postings. Regarding the actual hours staff worked not being included on the form, E2 (DON) stated, "... No it doesn't. And they all work different hours too. I didn't know..." A Facility Data Sheet, dated 11/07/13 and completed by E12 (Health Information Coordinator), indicates there are 78 residents residing at the facility.	F 356		