STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145751	A. BUILDING _____ B. WING _____	06/11/2013

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P A PETERSON CENTER FOR HEALTH	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

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F 000	INITIAL COMMENTS Annual Certification Survey Complaint Investigaton #1312118/IL#63419 - F323	F 000		
F 225 SS=E	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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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 conduct thorough investigations for allegations of abuse. The facility failed to investigate bruises and injuries of unknown injuries.

This applies to 3 of 20 residents (R34, R57, R101) reviewed for abuse in the sample of 20 and 2 residents (R106, R107) in the supplemental sample.

The findings include:

1. On 12/9/12, R101 reported an allegation of physical abuse against E17, CNA (Certified Nursing Assistant). E17 stated to E20 (Registered Nurse) that R101 had thrown his food tray all over the room. E20 documented she entered R101's room and noted the food tray at the end of the bed on the floor with food scattered all over the floor. R101 was lying in the bed with coffee splashed on his right cheek, ear and pillow. E20 noted an approximate 1/2 inch by 0.25 inch long wound to the top of R101's head and a scrape to the top of his nose. When E20 asked R101 what had happened, he stated he had tipped over his tray. E20 asked R101 how he acquired the wounds on his head and nose, he had stated E17 had thrown a cup at him.

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On 12/9/12, E3 (Director of Nurses) interviewed R101 following the incident. E3 documented there was coffee and breakfast food on the floor. E3 documented during the interview R101 again stated the CNA had thrown a cup at him and that is why he had a cut on his head.

On 12/9/12, E21 (Chaplain) documented an interview with R101. Documentation shows that R101 had stated E17 had hit him with a cup.

An undated summary of the the abuse committee meeting on 12/11/12 shows a review of the interviews to be inconsistent and R101 had documented outbursts/anger that he directs at staff and other residents by throwing objects or striking out. The care plan for R101 shows his is at risk for injury related to being argumentative. An intervention listed on the care plan for R101 shows staff is to assist R101 two at a time due to his behaviors.

The abuse committee concluded the incident timeframe was approximately 5-10 minutes. The committee documented the history of aggressive behavior towards staff and other residents and physical evidence, the allegation of physical abuse was not founded.

On 6/6/13 at 1:00 PM, E5 (Abuse Coordinator) stated, "We feel he (R101) had hit himself in the head with the cup as he was throwing it but we can not say for sure." E5 stated the committee still can not state where or how the laceration was acquired. E5 states " the committee does believe the incident happened but R101 is explosive." E5 had no response when asked if

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any other staff or residents were interviewed about this incident. No other documented interviews were presented by E5.

2. On 4/17/13 at 12:30 PM, R34 reported to day shift staff, the night CNA was "very rough and rude" to her. The aides assigned to care for R34 during the night shift were both agency nursing aides. E5 stated the agency was contacted and they would be conducting their own investigation.

The MDS (Minimum Data Set) dated 4/10/13, shows R34 to have a BIMS (Brief Interview for Mental Status) of 15, without any cognitive impairment.

On 6/6/13 at 1:30 PM, E5 presented two interviews of the involved aides. The interviews were conducted by the agency. E5 presented an investigation file with two written notes dated 4/17/13. The documents do not have signatures of the writer. No interviews with other residents on the same floor were presented.

On 6/6/13 at 1:30 PM, E5 stated that both CNA's have not been back. " We feel more comfortable not having them back in here."

On 4/22/13, the final report on the investigation into possible verbal abuse did not meet any definitions of verbal abuse and the committee determined no verbal abuse occurred. No further investigation was conducted.

On 4/29/13, a report of alleged verbal abuse was reported to the Department of Public Health. The comments on the report state "Resident has a history of negative statements. Facility has

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spoken to family, resident, and staff. Statements are not consistent . It is difficult to determine accuracy of events. No actual identified person at this time."

On 6/6/13 at 2:00 PM, E5 clarified that due to the inconsistencies of the CNA's account of the incident, that is was unfounded." E5 could not present any documented interview with R34 about the incident on 4/29/13. E5 had no response when asked why R34 was not interviewed when she had no cognitive impairment.

On 5/3/13, a final report was filed noting that "with no collaboration from patient and further interview of staff we find the allegation to be unfounded."

The facility Abuse Prevention Program Investigation Procedures dated 2011, shows the procedure to involve an interview with the resident. Interviews with other residents to which the accused individual has regular contact. Interview with staff members having contact with the resident and accused individual during the period of the alleged incident.
3. R57's Minimum Data Set (MDS) of 4/3/13 documents the resident has short and long term memory deficits. R57's Physician Order Sheet (POS) for June 2013 documents her diagnoses includes: Alzheimer Disease, Depressive Disorder, Anxiety, and Dementia with Agitation.

A Nurse Practitioner Progress Note of 2/25/13 states, "Staff request patient be evaluated due to unexplained bruising that was thought to have occurred Saturday night because it was noted on Sunday morning. Staff reports that patient has

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had no recent falls that they are aware of. Patient has bruising to her face, hands, bilateral lower extremities, and neck. Patient is not currently on any blood thinners."

A facility's Incident/Accident Report dated 2/18/2013 shows R57 only has bruising to an area above her right eye. There are no other notations on the body diagram. An Injury of Undetermined Origin Investigation Record of 2/18/2013 states, "Resident may have turned her head towards the side rail and may have hit the right side of her head/eye on it. There is no further investigation into the bruising on the resident's neck and lower extremities. The facility interviewed 3 staff members, 2 Licensed Practical Nurses and one other person. All 3 interviewees stated they did not know about the bruises. No other staff were interviewed that may have possibly seen and/ or cared for R57.

On 6/4/2013, R57 was observed lying in bed at 11:00 AM. The resident had bed bolsters on either side of her and a raised 1/4 side rail.
4. On 6/6/13 at 1:30 PM, E5 (Abuse Coordinator) stated R106 was discharged on 8/31/12. E5 said after a resident is discharged, the facility sends them a satisfaction questionnaire. E5 stated upon R106 receiving the questionnaire, she (R106) made the decision to call the facility rather than complete the questionnaire. R106 placed a call to the facility and alleged "mistreatment" by E18 (Certified Nursing Assistant - CNA) while a resident at the facility. R106 spoke with the "Ex-Administrator" according to the "report form." E5 stated at this time an investigation for neglect/abuse was initiated.

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The initial report documentation showed R106 stated she was not to be up walking at night per Therapy instructions and was to use a commode. R106 alleged when she would turn on her call light for assistance, E18 would tell her she needed to walk to the bathroom. R106 alleged when she would turn on her call light, E18 would come in and say she would be back in 10 minutes and then never return. R106 said on three occasions she waited at least an hour for someone to respond to her call light and on a 4th occasion waited 45 minutes. R106 stated on at least two of the extended call light responses, E18 was the CNA on duty. R106 described E18 as "mean".

On an undated/un-timed piece of documentation, E2 (Social Service Director (SSD)/Assistant Administrator) showed she called R106 to "clarify" information. In this documentation, it is written E18 made R106 feel like E18 was "annoyed" with her and that R106 was "bothering" E18 and taking her (E18) away from another task.

On 9/17/12, E18 wrote a statement which stated E18 was assisting R106 to ambulate to the bathroom and R106 complained of "straining her leg." The statement includes that R106 expressed concerns about waiting for response to her call light since 6:00 AM (unknown time of response to call light) and was "yelling mean things" so E18 "excused herself and sent another CNA" to care for R106.

On 9/18/12, E9 (Licensed Practical Nurse - LPN) stated when E18 left the floor on 9/17/12, another CNA approached E9 to report R12 was expressing concerns on care given to her by E18.

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This statement pens R12 was trying to tell E18 how best to apply her compression stockings so as to cause her (R12) the least amount of pain. R12 stated E18 "got mad and threw the stocking down" and left the room. In a follow up interview with R12, it was stated "This morning I was trying to tell her how to put my stockings on and she got mad and left and never came back." E9 stated agency staff don't like to work with E18 as she is "bossy." E9 also reported she has had complaints that E18 will not help in the dining room and she (E9) has witnessed that E18 "presents an attitude," and "is not an active team member."

On 9/18/12, E22 was interviewed and stated E18 can be "sassy." R24 was also interviewed and stated E18 is "rude."

The undated summary of the findings documents the following: "The committee has determined the allegation of suggested neglect is unfounded. The committee does believe that there is a customer service issue..."

A "Counseling Resolution Statement dated 9/20/12 showed the following: "(E18) does come across to some of her residents as being annoyed when they have a request. It was mentioned that she acts bothered when performing some tasks. She avoids call lights. Staff members state she acts disrespectful, she can be 'bossy.' CNA staff stated they would prefer not working with her..." The Corrective Action Plan: "As a level 11 CNA, (E18) is to act as a role model and this has not been done. She is to serve as a mentor to new CNA's, this has not happened. Maintain above average work

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performance. By the concerns brought forth by some residents, this is not always true. As a result, (E18) will be removed from the Level 11 program . . . (E18) will also be transferred to the second floor."

On 6/6/13 at 1:30 PM, E2 and E5 were asked how the committee came to their conclusion. E2 stated E18 was having some personal issues/stressors in her life that were affecting her work performance so that was taken into consideration. E2 stated no information could be obtained to prove care was or wasn't given. When asked if E18 was questioned about whether or not she did return to provide cares when allegations of her leaving the rooms were made, E2 and E5 stated there is no documentation of that aspect being investigated. E5 stated, "that was 9 months ago so I can't remember specifics." E2 stated "I am sure the care was given but I have no idea how much later it would have been."

5. An investigation of alleged abuse, dated 8/16/12, was reviewed. R107 alleged being afraid of E19 (CNA). According to E24's (LPN) written statement, R107, R108 and R109 were seated at a dining room table talking about their care experiences with a staff member "who isn't nice." R107 was heard to say she is "afraid of her," R109 stated "I'm not afraid but she isn't nice," and R108 said "she wasn't nice to me when I first came here." E24 questioned the residents who acknowledged they were discussing E19. R109 told E24 "she is the only mean one here." R107 told R24 that when E19 "was helping me in bed, she hurt" me by moving my legs to quickly/fast.

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On 8/16/12, E2 (SSD) interviewed R107 who stated "vulnerable" would be a more accurate description than fear. R107 felt E19 was "abrupt and impatient." R108 told E2 that E19 had an attitude and was abrupt. R108 said E19 would approach her and say "what do you need?"

On 8/16/12, E4 (Assistant Director of Nursing - ADON) spoke with R109. R109 said E19 has an abrupt manner. R109 said her first day in the facility E19 told her she needed to learn to take care of her colostomy herself. The second day, E19 told her she wasn't the only patient here.

A statement written by E25 (Registered Nurse - RN) stated E19's attitude toward the patients can be very short. E19 has been overheard giving one word short answers and sometimes even does not verbally respond at all. E25 said E19 will just make a "sound" instead of answering.

An undated statement written by E26 (RN) documented the following comments regarding E19: "She's not as good a team player as she could be. She does not offer help, acts resentful when asked and prefers to do her own work even if it means having call lights going off on her patients rather than accepting help knowing she should reciprocate. She also gets bossy and short..."

A statement dated 8/8/12 at 4:40 PM showed E27 (Physical Therapy Aide) was taking R110 to therapy when she saw E28 (RN). R110 gave E28 a hug and began crying stating she couldn't help it that water just goes right through her. E28 stated the staff (CNA's) were telling her they

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F 225	Continued From page 10 couldn't be changing her all the time. R110's daughter (Z2) told the facility her mother (R110) stated she feels like a nuisance and reported the floor staff "counts" the number of times she goes to the bathroom. Z2 states it makes R110 feel "BAD." According to the documentation of Z2, R110 is totally dependant on staff for toileting needs. According to the Counseling Resolution Statement dated 8/17/12, "it was determined by the facility that there was no willful intent to cause harm. It was determined that (E19) is perceived by patients and staff members as being abrupt, "bossy", not a team player and impatient." The corrective action includes: "Will meet with Supervisor regarding how she needs to work on improving her apparent attitude with her team members and patients. Will meet with Staff Educator regarding customer service prior to returning to her normal schedule." On 6/6/13 at 2:35 PM, E5 (Abuse Coordinator) stated that E19 likes to handle her own assignments because she takes accountability for her cares. When asked about residents cares/needs not being met related to prolonged call light waits, E5 stated the committee hadn't looked at it from that perspective. E5 states eventually the care gets done.	F 225		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 272	Continued From page 11 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete the Care Area Assessment (CAA) including the location and date of the	F 272		

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related information for the assessments.

This applies to 7 of 20 residents (R16, R31, R62, R36, R66, R92, R59) reviewed for assessments in the sample of 20.

The findings include:

R16's Minimum Data Set (MDS) CAA of 9/19/12 had no dates or locations of where to find the assessment information for verification.

R31's MDS CAA of 4/3/13 had no dates or locations of where to find the assessment information for verification.

R62's MDS CAA of 7/11/12 had no dates or locations of where to find the assessment information for verification.

R36's MDS CAA of 5/8/13 had no dates or locations of where to find the assessment information for verification.

R66's MDS CAA of 5/21/13 had no dates or locations of where to find the assessment information for verification.

R59's MDS CAA of 5/10/13 had no dates or locations of where to find the assessment information for verification.

R92's MDS CAA of 12/3/12 had no dates or locations of where to find the assessment information for verification.

The Care Area Assessment Summary (Section V) in the MDS states to "indicate in the Location and

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F 272	Continued From page 13 date of CAA Documentation column where information related to the CAA can be found". On 6/6/13 at 3:40 PM, E1 (Administrator) and E3 (Director of Nursing) verified locations and dates were missing on the CAAs.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop comprehensive care plans for a resident (R17) with orders for continuous oxygen, and a resident (R36) who requires total assistance with toileting needs. The facility failed	F 279		

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to develop care plans residents at risk for abuse. This applies to 2 of 20 residents (R17, R36) reviewed for care plans in the sample of 20 and 4 residents (R101, R107, R106, R34) in the supplemental sample.
The findings include:
R17 ' s Physician ' s Order Sheet (POS) dated 5/23/13 documents that R17 has diagnoses to include Coronary Artery Disease (CAD), Hypertension (HTN), and Chronic Obstructive Pulmonary Disease (COPD). R17 ' s POS has an order dated 8/2013 for " oxygen at 2L/MIN per nasal cannula continuous " .
On 6/4/13, R17 was observed without her oxygen on from 11:45AM until 11:55AM, and 12:55 PM to 1:15 PM.
On 6/5/13 at 9:25 AM, R17 was sitting outside the nurse station without her oxygen on. E9 (Licensed Practical Nurse - LPN) said R17 ' s oxygen had been off for about 15 minutes, and R17 just returned from the bathroom. E9 said R17 should have her oxygen on at all times.
R17 ' s plan of care does not include a care plan or interventions for COPD, or oxygen use.
On 6/5/13 at 1:45 PM, E8 (Care Plan Nurse) said R17 should have a care plan and interventions for oxygen use.
2. According to the facility face sheet, R36 was admitted to the facility on 1/18/12 in the sheltered care area. The nursing notes showed R36 was transferred to the Alzheimer's Dementia Unit on 4/26/13. The Minimum Data Set dated 5/8/13 identified R36 as being totally dependant on one person physical assist of staff for toilet use.

No care plans could be located for R36 on 6/5/13. On 6/6/13, the facility produced care plans with onset dates of 6/5/13. No care plans prior to this

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F 279	Continued From page 15 date were provided. 3.Care plans for residents at a high risk for abuse due to behaviors were revewed. Care Plans for R101, R107, R106 and R34 were all reviewed. A review of the care plans showed these residents to not have a care plan to address being at risk for abuse. On 6/6/13 at 1:30, E5 stated that all residents are at risk for abuse. E5 stated " we do not assess residents for abuse, we feel that everyone is at risk for abuse. We will target the behavior that puts someone at risk for abuse."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure a resident's care plan is reviewed and revised when changes occur.

This applies to 1 of 20 resident's (R91) careplans reviewed in the sample of 20.

The finding includes:

R91's Minimum Data Set (MDS) of 4/24/13 documents the resident is usually incontinent of urine, has severe cognitive deficits and requires extensive assistance with bathing and hygiene.

On 6/4/2013 at 2:30 PM, E12 and E13 (Certified Nursing Assistants - CNAs) were observed transferring R91 from her wheelchair to her bed. The resident smelled strongly of urine. After the resident was transferred into bed, she was undressed. The resident's adult incontinence brief was saturated with urine. E12 said the last time the resident was changed was before noon. E12 said the only time R91 is toileted is when she asks to be.

R91's 4/24/13 careplan shows the resident is on a scheduled toileting plan. Her goal is that she will have no more than 3 episodes of urinary incontinence per waking hours, and no skin break down related to incontinence. One of the interventions of the care plan is that the Restorative department will conduct an ongoing assessment of R91's voiding patterns.

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F 280	Continued From page 17 On 6/5/2013 at 10:40 AM, E14 (Restorative Licensed Practical Nurse) said R91 is no longer on a toileting plan.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff toilet a resident and provide peri care in a manner to prevent cross-contamination for a resident with a history of Urinary Tract Infections. This applies to 2 of 17 (R91 & R36) residents reviewed for incontince in the sample of 20. The findings include: 1. R91's Minimum Data Set (MDS) of 4/24/13 documents the resident is usually incontinent of urine. She has severe cognitive deficits. R91 requires extensive assistance with bathing and hygiene. On 6/4/2013 at 2:30 PM, E12 and E13 (Certified	F 315		

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Nursing Assistants - CNAs) were observed transferring R91 from her wheelchair to her bed. The resident smelled strongly of urine. After the resident was transferred into bed, she was undressed. The resident's adult incontinence brief was saturated with urine. E12 said the last time the resident was changed was before noon. E12 provided the resident incontinence care. The resident's buttocks and upper thighs were not cleansed to remove the urine from the resident's skin. E12 said the only time R91 is toileted is when she asks to be.

R91's 4/24/13 careplan shows the resident is on a scheduled toileting plan. Her goal is that she will have no more than 3 episodes of urinary incontinence per waking hours, and no skin break down related to incontinence.

The facility's Female Perineal Care Policy and Procedure (undated) states, "Perineal care is done at least daily...and whenever the area is soiled with urine or feces.

On 6/6/2013 at 3:45 PM, E3 (Director of Nursing) verified all skin that becomes wet or soiled with urine or feces should be cleaned.

On 6/5/2013 at 10:40 AM, E14 (Restorative Licensed Practical Nurse) said R91 is no longer on a toileting plan. E14 said the resident should be toileted before and after meals, in the morning and in the evening before going to bed.
2. R36 is a resident residing on the Alzheimer's Dementia Unit in the facility. The Minimum Data Set dated 5/8/13 identified R36 as being totally dependent on one person physical assist of staff for toilet use.

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R36's urinalysis laboratory report dated 4/15/13 showed R36 had a Urinary Tract Infection with the causative organism identified as Escherichia Coli (E. Coli).

On 6/6/13 at 10:30 AM, E6 (Certified Nursing Assistant - CNA) took R36 to the bathroom and provided peri-care. R36 stood in front of the commode as E6 donned gloves. E6 pulled down R36's slacks and incontinent brief. R36 had a solid lump of feces attached to her buttock. E6 removed the incontinent brief after R36 was seated on the commode as it contained a stool smearing. E6 washed her hands and donned a new pair of gloves to apply new brief. After R36 was finished using the commode, she again stood up in front of the stool and E6 provided peri care. E6 wiped the stool from R36's buttocks with toilet paper. After 6 times of wiping her buttocks, E6 obtained a wash cloth from the sink, still wearing the gloves used to cleanse the stool from R36's buttocks. E6 approached R36 from behind, reached through her thighs and swiped the peri area and pulled backwards and up the buttocks. E6 used the same technique for rinsing and drying R36, while continuing to wear the gloves that had been worn to cleanse the stool from R36's buttocks.

No care plans could be located for R36 on 6/5/13. On 6/6/13, the facility produced care plans for R36 which had an onset date of 6/5/13. The care plans identified concerns of "unable to provide proper personal hygiene and bathing" and "occasional episodes of urinary incontinence," with an intervention listed of "Please have staff CNA assist me with changing my soiled clothing

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F 315	Continued From page 20 after each incontinence episode," and " Please have staff CNA help me cleanse my skin with appropriate cleanser and water after each incontinence episode."	F 315		
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, interview, and record review the facility failed to supervise a transfer to the toilet and failed to use a gait belt with ambulation for a resident at high risk for falls. This is for 1 resident (R2) reviewed for falls in the supplemental sample. The findings include: R2 ' s 5/2/13 Minimum Data Set Assessment shows R2 was admitted on 4/25/13. R2 is cognitively intact, and needs extensive assistance of one person for transfers and ambulation. On 5/24/13 at 1:00 PM, R2 was sitting in a wheelchair. R2 had a bruise on the right side of the forehead. R2 ' s right arm/hand was wrapped in a dressing. R2 ' s left arm/hand had multiple bruises. R2 stated, " I get wobbly when I get up. "	F 323		

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R2's Incident/Accident Reports show falls occurred on 5/6/13 at 9:20 PM & 5/21/13 at 1:55 PM. R2 ' s 5/21/13 Report states, " Patient was in the bathroom lying sideways with head lying on the tub, skin laceration to the forehead and multiple skin lacerations to the right arm & wrist and ecchymosis to the right rib area. The patient states he was trying to sit on the toilet and fell. Neuro signs pupils equal, hand grips equally strong, good range of motion, denies nausea, dizziness or lightheadedness."

On 5/24/13 at 1:10 PM, Z1 (Physical Therapy Aide) stated on 5/21/13, " I went to take [R2] to therapy. It was the first time I had seen him. [R2] wanted to use the bathroom before we left the room. I asked if he needed help and [R2] said no, but I walked with [R2] to the bathroom. [R2 ' s wife] said there was a gait belt in the room to use while walking. I said we ' ll put it on afterwards because we were already half way there. In the bathroom, [R2] said he could manage. [R2] was half way to a sitting position on the toilet when I stepped out of the bathroom. 30 seconds later, I heard a noise and found [R2] had fallen half way into the tub. [R2] had hit his head and was bleeding."

On 5/24/13 at 12:50 PM, E5 (Registered Nurse) stated, " Residents should never be left alone while in the bathroom. " After a resident is seated on the toilet and the call light is within reach, staff may step outside the bathroom door to allow for privacy. " [R2] always says ' I can do it ' which gives people the impression he can do more for himself then he is capable of at the moment." It is a mixture of denial and confusion.

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R2 wants to prove he has strength to do things.

On 5/24/13 at 3:35 PM, E7 (Care Plan Coordinator) said that each room has a dry erase board on the wall. The board has the pertinent information about assistance that is needed for transfers and ambulation. Physical Therapy keeps the board updated as changes occur.

R2 ' s 4/25/13 Falls Care Plan shows R2 at risk for falls related to hepatitis with encephalopathy. Care plan approaches include: Remind to ask for assist for all ambulation as needed & Monitor for changes in condition that may warrant increased supervision/assistance. On 5/7/13 the following approaches were added to the care plan after R2 ' s first fall: Monitor balance prior to transfers & Monitor for any dizziness prior to transfers. On 5/21/13, after the second fall, these approaches were added: Gait belt with ambulation; move to room 212 for observation, bed/chair alarms.

The facility's Gait Belt policy states, "Nursing staff will utilize gait belts on residents needing one person assistance or more in transferring and ambulation... Promote ambulation by providing increased security for resident and staff... and allow the employee to gradually lower a resident to the floor, if this becomes necessary, without injuring the resident or the employee."

The facility ' s Fall Risk Assessments policy states that a score of 10 or above indicates that a resident is at high risk for falls. R2 ' s admission Fall Risk Assessment of 4/25/13 was a score of 11. R2 ' s 5/6/13 Fall Risk Assessment (done after the first fall) was a score of 9 (scoring R2 at less of a risk than when he was admitted). R2 ' s

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F 323	Continued From page 23 Fall Risk Assessment was done on 5/21/13 after the second fall scored 20. The Facility ' s undated Fall Prevention-Falling Star Program policy states, " The Fall Risk Assessment will be updated by the nurse after each fall ... must be updated with any changes or declines in the resident ' s level of functioning ... " " The nurse will provide education to the resident and their family members regarding the resident ' s high risk for falls and the preventative measures taken to ensure the resident ' s safety."	F 323		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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F 441	Continued From page 24 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to track and trend resident infections and employee illnesses. The facility also failed to ensure staff change contaminated gloves and wash a residen'st hands after toileting. This applies to all residents residing in the facility. The findings include: 1. The 672 of 6/4/2013 documents 99 residents reside in the facility. The facility's infection control log was reviewed. The log did not show if cultures were done or the findings of the culture, enabling the facility to track infectious organisms. There was no log or method to track employee illnesses. On 6/6/2013 at 4:00 PM, E3 (Director of Nursing) verified the facility did not track infectious organisms or employee illnessess as part of their infection control surveillance.	F 441		

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2. R57's Minimum Data Set of 4/3/13 documents the resident is incontinent of bowel and bladder. She requires extensive assistance with hygiene and bathing.

On 6/4/2013 at 11:45 AM, E15 and E16 (Certified Nursing Assistants) were observed providing peri care to R57. R57 was incontinet of a small amount of stool. E15 donned a pair of gloves, and cleansed the stool from the anal area first. E15 did not removed the contaminated gloves. She continued providing peri care, cleansing first back to front and front to back. When E15 completed the peri care, she still did not remove her soiled gloves. E15 opened the night stand drawer and obtained a tube of barrier cream, contaminating the tube of cream and the night stand drawer. E15 handed the tube of barrier cream to E16, contaminating E16's gloves also.

The facility's undated Glove Technique, non sterile, states, "...Change gloves in between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganismsd to other residents.

3. On 6/6/13 at 9:10 AM, E11 (Certified Nurse Assistant-CNA) transferred R31 from her wheelchair to the toilet. R31 placed her left hand on the bathroom support bar and used her right hand to help pull her soiled incontinence brief down. R31 then placed both hands on the toilet support bars to lower herself on the toilet.

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F 441	Continued From page 26 E11 provided incontinence care to R31 and did not change her gloves before pulling up R31 ' s clean incontinence brief and pants. E11 assisted R31 to her wheelchair with the same gloves on, potentially contaminating R31 ' s clothing and wheel chair surfaces. E11 wheeled R31 into the hallway without washing R31 ' s hands. On 6/6/13 at 9:20 AM, E11 said she should have washed R31 ' s hands after toileting. On 6/6/13 at 1:30 PM, E3 (Director of Nursing - DON) said staff should change their gloves and cleanse their hands after providing incontinence care, and prior to touching clean linen and contact surfaces. E3 said the facility does not have a policy to wash resident hands after toileting but it is a CNA job expectation that resident ' s hands are washed after toileting.	F 441		
F 516 SS=C	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 516		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145751	A. BUILDING _____ B. WING _____	06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
P A PETERSON CENTER FOR HEALTH	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

(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 516	Continued From page 27	F 516		

review the facility failed to ensure medical records were protected from water damage when stored under sprinklers.

This applies to all 99 residents.

The findings include:

The facility's Resident and Cencus and Condition form-672(dated 6/5/13) shows a total census of 99 residents.

On 6/5/13 at 9:45 AM, during the environmental tour, thinned medical records on the third floor were stacked on top of filling cabinets. At 10:00 AM, in another area of the facility, more thinned medical records in the medical record storage room were stacked on top of filling cabinets or stacked in plastic containers without covers in the medical records storage room. The medical records were stored in areas with sprinkler heads directly above.

On 6/5/13 at 9:45 AM, E7 (Director of Building Services) stated, "The files should be protected from water damage."

The non-dated facility policy titled, Storage of Records, states, "Policy Statement: Medical records shall be stored in a safe and secure location."