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	145751	A. BUILDING _____ B. WING _____	04/28/2015

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VILLA AT PA PETERSON,THE	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	Annual Licensure and Certification Survey 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		

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

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to immediately report an allegation of abuse, and the facility failed to immediately suspend an employee after an allegation of abuse was made to a nurse. This applies to 1 resident (R30) in the supplemental sample. The findings include: R30's Nurse Notes 3/4/15 at 10:37 shows: Patient reported CNA (Certified Nurse Assistant) was "being rude and not careful when he banged the walker in this LLE (left lower extremity) while sitting on the toilet." The facility Abuse Prohibition form shows R30 reported the incident again to E33 (Admissions Director) on 3/5/15 at 3:00 PM (16 hours after the nurse was aware of the event). R30's Abuse Prohibition Interview dated 3/5/15 shows that a CNA entered R30's room approximately 9:00 PM and the resident asked for assistance. The CNA responded "that he [R30] could do all of that himself, " and the CNA assisted him to the bathroom and "when moving his walker he threw it sideways and hit" R30's right knee. The interview shows R30 said this event made him feel "weak." The undated facility interview with E35 (Nurse who wrote the 3/4/15 nurse note about event) shows R30 said he told E34 (CNA) something and E34 threw his arms in the air and said something about not wanting his help. On 4/23/15 at 10:30 AM, E2 (Director of Nursing - DON) said when the allegation of abuse was	F 225		

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F 225	Continued From page 2	F 225		

reported to them on 3/5/15 by E33 she started an investigation. E2 said E35 (Nurse) did not report the event on 3/4/15 as an allegation of abuse. E2 said the investigation did not begin until R30 reported the event again the next day to the Admissions Director. E2 said R30 was not suspended from patient care until 3/5/15. E2 said a staff member talking rudely to a resident could be considered verbal abuse.

On 4/25/15 at 11:45 AM, E2 said after R30 told the nurse that E34 was rude, he did not care for R30 the rest of that shift. E2 said R30 did care for the rest of the residents on the unit until his shift ended.

On 4/23/15 at 10:10 AM, E13 (Abuse Coordinator) said if an allegation of abuse is made against a staff member the staff member should be suspended from patient care immediately. E13 said an allegation of abuse should be reported immediately to the administrator and an investigation started.

On 4/23/15 at 1:00 PM, E1 (Administrator) said all types of abuse included physical, mental, sexual, and verbal should be reported by the staff to the administrator immediately. E1 said an employee accused of abuse should be taken off the floor immediately. E1 said if a patient reports that a staff member is being rude, the staff should then recognize that as potential verbal abuse.

On 4/24/15 at 9:20 AM, E31 (Licensed Practical Nurse - LPN) said if a resident reported to her that a CNA is rude she would " reassign the CNA from the resident and call social services to come talk to the resident." E31 said if a resident reports a nurse is "rude" it "would fall into the abuse category." E31 did not say the staff member should be removed from patient care immediately and may return only after the investigation is completed and unfounded.

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F 225	Continued From page 3 On 4/24/15 at 9:30 AM, E32 (CNA) said if a resident reports to her that another CNA is being rude, it should be reported to the nurse right away and could be considered verbal abuse. The 2011 facility policy Abuse Prevention Program Facility Policy shows: "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion...Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend or disability."	F 225		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide activities to meet individual preferences and cognitive needs. This applies to 1 (R1) of 12 residents reviewed for activities in the sample of 20. R1 was not observed in any active or passive activity during the survey from 4/21/15 through 4/24/15 to include group, 1:1, listening to music or religious services. On 4/24/15 at 9:05 AM, E28 (Certified Nurse's Aide-CNA) & E 29, CNA stated that R1 has not	F 248		

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F 248	Continued From page 4 participated in any group activities for at least two months and cannot communicate or actively participate in activities. E28 stated that R1 had not been involved in any one to one activities the past few days because they have had agency staffing the unit. E28 & E29 agreed that during their shift, R1 is in bed or at meals. On 4/25/15 at 8:30 AM, E14, CNA stated that R1's daily routine is to be transferred from her bed to a wheelchair and pushed to dining room for breakfast. After breakfast, R1 is transferred back to bed until lunchtime. At lunchtime, R1 is transferred to the wheelchair and transported to dining room. After lunch, R1 is transferred back to her room where she remains until the end of their shift. The MDS dated 10/29/14 & 1/29/15 documents that R1 considers it very important to do things with groups, be around animals, such as pets, listen to music, religious services and get some fresh air. The activity schedule for 4/21-4/24/15 shows numerous opportunities for group and religious activities. R1's care plan dated 7/23/14 lists for interventions to continue to encourage my involvement in the life of the facility, continue to assist me to keep me stimulated, offer sensory stimulation material and relaxation techniques and offer 1:1 visits to increase my awareness of my environment and socialization.	F 248		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 5 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to coordinate necessary care and services with the dialysis center to ensure new medication orders were implemented. The facility failed to assess for, care plan, and implement non-pharmacological interventions for a resident with dementia. This applies to one of one residents (R14) reviewed for dialysis in the sample of 20, and one of six residents (R17) reviewed for behaviors in the sample of 20. The findings include: 1. On 4/23/15 at 9:10 AM, E24 (Licensed Practical Nurse - LPN) stated R14 receives dialysis outside the facility three days each week on Tuesdays, Thursdays and Saturdays. On 4/23/15 at 9:30 AM, E22 (Registered Nurse, Unit Manager) presented a communication book that is used with the dialysis center. The book showed written communication returned from the dialysis center two days earlier (4/21/15) that included a physician order to start Tums two tablets of 750mg with meals, three times daily. The surveyor asked if the new order would be included on R14's medication administration record (MAR) and E22 replied "It should be." The surveyor and E22 checked the April 2015 MAR for R14 and the order had not been transcribed or carried out. A fax from the dialysis center (also dated 4/21/15) shows "Prescribed Phosphorus Binder: start Tums (750mg) 2 tablets with meals three times daily."	F 309		

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The facility's undated General Communication and Coordination of Care policy for dialysis patients lists "2. A dialysis communication sheet will be used by dialysis provider during treatment and given to [skilled nursing facility] after treatment as a summary and communication record ... 4. The intra facility-communication is done to discuss resident's plan of care."
R14's care plan of 4/8/15 does not show what specific type of dialysis access he has or where it is located. The care plan contains no specific information related to R14's dialysis center, days of the week he goes, or how to arrange for transportation. The care plan had not been updated to reflect the addition of the phosphorous binder.
On 4/24/15 at 9:10 AM, R14 was sitting in a recliner in the lounge with his head down. He said his dialysis access was in his left arm. There was a pink band on his right wrist that read "No blood pressure/no blood draw" on it.
2. R17's Minimum Data Set (MDS) from 3/8/15 lists diagnoses of Dementia and Anxiety. R17's Physician Order Sheet for 4/2015 shows R17 takes Xanax 0.25mg (anti-anxiety medication) at night for her anxiety.
On 4/21/15 at 10:30 AM, R17 was sitting in her wheelchair in her room, crying. On 4/22/15 at 11:10 AM, R17 asked to speak with the surveyor and discussed various concerns she had and cried throughout the 25 minute conversation. R17 discussed her concerns and worries about getting to the bathroom, adjusting to facility life, the progression of husband's health problems, their home in the community, their children, and the general future for her and her husband. E22 (Registered Nurse - RN, Unit Manager) states some of R17's weepiness is a behavior, and (R17) is now taking an antibiotic for an illness,

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which has made her behaviors worse. At 9 AM on 4/24/15, E36 (Certified Nursing Assistant - CNA) states (R17) "gets in her moods" and we redirect her.
The Abuse/Neglect Assessment for R17 dated 12/19/15 identifies depression/anxiety and cognitive impairment as risk factors. Additional comments show "Resident is often sad and crying about various things. Anxiety can run high." Nursing notes from 1/25/15 show R17 was "very weepy" and was "thinking 'I'm (R17) in the way.'" The nursing note from 1/29/15 shows "Resident confided in the nurse about how depressed she is." On 2/20/15, the facility obtained an order to increase R17's anti-anxiety medication to twice daily, but R17 did not consent to the increase and the second dose was discontinued.
An undated social service progress note shows "On 3/17/15 nursing informed social services [R17] was feeling down." On 4/24/15 at 9:15 AM, E12 (Social Services) said the only depression assessment used in the facility is in the Minimum Data Set assessment (MDS). E12 stated staff and unit managers will communicate with her verbally if residents are having concerns. E12 stated she writes the care plans for depression and will refer residents for psychiatric evaluations when needed.
The care plan initiated on 3/17/15 shows a focus of "resident uses anti-anxiety medication related to anxiety disorder" and a goal to "be free from discomfort or adverse reactions related to anti-anxiety therapy." The only intervention listed for this focus is to administer anti-anxiety medications as ordered by physician and monitor for side effects and effectiveness each shift. The care plan does not identify depression or crying as behaviors or specifically how staff should

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F 309	Continued From page 8 respond to them.	F 309		
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 maintain a safe environment by not securing the door to a storage area containing broken glass and hazardous chemicals. The facility failed use of a gait belt to promote safety when tranfering a resident. This applies to 7 residents (R27 & R32-R37) reviewed for safety and supervision in the supplemental sample. 1. The facility census shows R32-R37 reside on the Dementia Unit. On 4/21/15 at 10:50 AM, the electrical room door was not locked. Inside the room was broken glass, an aerosol can of 3M Super 77, an aerosol can of Lysol Nutra Air, fuse and electrical boxes... On 4/21/15 R37 pushed on doors attempting to open them and enter the adjecent area. On 4/22/15 numerous confused residents walked past the electrical room. The electrical room is adjacent to the nurse's station. On 4/21/15 at 1:30 PM, E 16 (Alzheimer Unit & Activity Director) stated that doors to resident room hallways were closed so wandering was	F 323		

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limited to common area around nurse's station.
On 4/21/15 at 10:50 AM, E16 stated that she was unsure why electrical room door was unlocked but that it should be locked.
On 4/21/15 at 2:20 PM, E2 (Director of Nursing-DON) stated that electrical room door should be locked for resident safety.
Facility Material Safety Data Sheet (MSDS) for 3M Super 77 shows inhalation may be harmful or fatal and ingestion may cause unconsciousness.
Facility MSDS sheet for Lysol Nutra Air shows product may be harmful or fatal if inhaled or ingested.
2. On 4/22/15 at 8:30 AM, E20 (Certified Nurse's Aide-CNA) removed a gait belt from R 27's waist and transferred her with difficulty from a wheelchair to a recliner. This surveyor alerted E19 (Licensed Practical Nurse-LPN) to the situation and she promptly assisted with the transfer.
On 4/22/15 at 8:30 AM, E20, CNA stated that she removed the gait belt from R27's waist when she complained of discomfort.
On 4/22/15 at 8:35 AM, E18 (LPN) who was aware of the situation stated that perhaps the gait belt was too loose and E20 should have gotten additional help if she was going to remove the belt.
On 4/22/15 at 8:55 AM, E16 stated that the gait belt could have been repositioned to accommodate R27's needs. E16 stated that gait belts are expected to be used with resident transfers.
On 4/23/15 at 1:00PM, E21 (Physical Therapist/Interim Director of Physical Therapy) stated that if residents require more than just a standby assistance to transfer it is protocol to utilize a gait belt.
The physical therapy initial assessment dated

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F 323	Continued From page 10 4/20/15 documents that R27 requires moderate assistance with transferring. The 4/22/15 (Record of Oral Counseling) documents that E20 was counseled regarding proper gait belt positioning and proper transferring.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents on pureed diets received the prescribed protein serving and failed to ensure a bread serving was served with the noon meal. This applies to 2 of 17 residents (R1, R16) reviewed for diets in sample of 20 and 3 residents in the supplemental sample. (R21, R22, R23) The findings include: The faciltiy menu list shows R1, R16, and R21-23 have an order for a puree diet. The menu for puree diets on 4/22/15 shows residents will be served Tex Mex Chili (6 ounce serving), cooked vegetable, fresh fruit cup, 1 slice cornbread for the noon meal. On 4/22/15 at 9:00 AM, E7 (Cook) stated all purees will be served chili, green beans, fresh honeydew melon, and cornbread for lunch today. E7 explained they also prepare mashed potatoes	F 363		

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F 363	Continued From page 11 and gravy for the puree diet to provide extra calories. On 4/22/15 at 11:50 AM, a resident room tray for R21 was noted to be pureed food. The puree meal had a small portion of chili (1/2 C or less), green beans and mashed potatoes all on the same plate. No fruit or bread serving noted. On 4/22/15 at 12:20 PM, in the kitchen (serving the ground floor residents) the serving ladle in the puree chili was 2 ounce. E4 (Dietary Manager) stated the residents should get a 3 ounce serving. We serve 1 ½ ladles for the chili serving. On 4/22/15 at 12:30 PM, E6 (Dietary Aide) had completed the food service on the Dementia care unit (3rd floor). E6 stated the kitchen sends the ladle or scoop to use when serving the meal. E6 stated the puree chili was served with one #12 scoop (1/3 cup). E6 stated she had not served any of the puree cornbread. E6 stated, " I thought if they were served potatoes, they didn ' t need bread serving too. That ' s too much starch. " The container of cornbread in the steam table did not have any portions removed. E5 (Dietary Supervisor) stated Residents can choose if they want a bread serving. E5 agreed however that residents with Dementia may not be able to choose what foods they prefer and the bread serving should be offered. The facility admission criteria for residents admitted to the Dementia unit states the resident must have a diagnosis of Non-Reversible Dementia, or Alzheimer disease. Residents admitted to the unit must also have impaired abstract thinking, impaired judgement, disturbances of higher cortical function or personality changes.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 12 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure raw fruit was thoroughly washed prior to preparation. This has the potential to affect all residents in the facility with the exception of 3 residents that receive gastric tube feedings (R6, R9, R12). The findings include: The Census and Condition Report (CMS 670) dated 4/21/15 shows 100 residents reside in the facility. The Roster Matrix (CMS 802) dated 4/21/15 shows R6, R9, R12 receive gastric tube feedings. On 4/23/15 at 1:35 PM, E2 stated R6, R9 and R12 do not consume oral foods. On 4/22/15 at 8:50 AM, eight honey dew melons were observed on a large plastic cutting board in the kitchen. The top and bottoms of the melon had been removed and 1 melon had been peeled, (Outer rind had been cut off). Another case of melon was observed on the counter still in the shipping box. E4 (Dietary Manager) stated he was preparing the melon for the dessert fruit cups and the cottage cheese fruit plates to be served at the noon meal. E4 was asked if the melon had been washed and E4 confirmed he had not done so prior to cutting the melons.	F 371		

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 _____	04/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT PA PETERSON,THE	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

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F 371	Continued From page 13 The facility menu for 4/22/15 showed the general, mechanical and puree diets would have a seasonal fruit cup for dessert, and the alternate lunch option was a cottage cheese fruit plate. On 4/23/15 at 11:40 AM, E4 (Dietary Manager) states it is the facility policy to ensure all fruit is washed prior to serving. The facility policy (undated), Preventing Cross-Contamination During Storage and Preparation states, " Separate unwashed fruits and vegetables from washed fruits and vegetables and other ready to eat foods. "	F 371		