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F 000	INITIAL COMMENTS Annual Certification Survey Investigation of Complaint # 1323336/IL 64887 - F223; F225; F226 Investigation of Complaint #1323373/IL64931- F223; F225; F226 Investigation of Resident Incident of 08/12/13/ IL #64928-No deficiencies Investigation of Complaint #1323411/IL 65022-F225 An Extended Survey was conducted.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to document a medical symptom justifying the use of a restraint and failed to have a restraint reduction program in place for one of three residents (R12) reviewed for physical restraints in the sample of 17. Findings include: R12's current Physician Order Sheet documents	F 221		

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

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R12 has a diagnosis of Dementia. R12's current fall care plan documents R12 has a intervention to use a self releasing seat belt.

On 8-13-13 at 10:40 a.m., E4 (Certified Nursing Aide/CNA) assisted R12 from the bed to a wheelchair. E4 then buckled a seat belt around R12's waist. E4 stated, "We put a seat belt on (R12) to keep (R12) from falling. (R12) cannot release the seatbelt by self." E4 asked R12 to release the seatbelt and R12 was unable.

On 8-13-13 at 11:00 a.m., R12 was sitting up in a wheelchair, at the dining room table, with a seat belt latched around the waist.

On 8-13-13 at 10:55 a.m., E5 (Licensed Practical Nurse/LPN) stated R12 does not have the cognitive ability to release the seat belt.

On 8-13-13 at 11:05 a.m., E6 (CNA) stated R12 cannot take the seat belt off even when asked to.

On 8-13-13 at 12:00 p.m., E7 (Restorative Nurse) attempted to have R12 release the seat belt by self multiple times. R12 was unable to release the seat belt. E7 states, "If (R12) cannot release the seat belt then I would consider it a restraint."

On 8-14-13 at 1:15 p.m., E7 stated, "I am not going to lie to you, I don't have a restraint reduction plan for (R12's) seatbelt use." E7 stated R12 is using the seatbelt for decrease safety awareness due to Dementia with falls.

The facility's physical restraint policy dated 10/2000 documents belts used in conjunction with a chair, that residents cannot remove easily and

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F 221	Continued From page 2 prevent a resident from rising, are prohibited. The policy also documents a care plan will be done to address the restraint usage, the medical symptom warranting the use of a restraint, interventions for restraint reduction or elimination, and interventions to minimize potential functional decline with restraint use.	F 221		
F 223 SS=L	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify the physically aggressive behaviors of two residents, R18 and R23, toward other residents as abuse, and failed to put interventions in place to protect the other facility residents from being repeatedly subjected to abusive behaviors by R18 and R23. R18 and R17, a severely cognitively-impaired resident, were roommates. Staff (E16) witnessed R18 hitting R17 in the chest on one occasion, resulting in R17 being sent to the local hospital emergency department and being diagnosed with "multiple traumatic injuries in various stages of healing, which are suspicious of physical abuse." R18 is ambulatory and had a history of entering other resident's rooms without permission and	F 223		

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even striking R21 in R21's room. R18 was witnessed hitting another resident (R39) in the dining room on another occasion.

R23 had two incidents of being physically aggressive to other residents, with the second incident resulting in pelvic fracture for R13, after being pushed to the ground by R23.

These failures have the potential to effect all 82 residents in the facility.

These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 8-14-13, the facility remains out of compliance at severity Level Two. Additional time is needed for the facility to complete staff education on behavioral monitoring, monitor the effectiveness of the implementation of protocols, and for oversight visits.

Findings include:

1. A physician's order sheet (POS) dated, 8/2013, documents that R18 has diagnoses which include: Asperger's Syndrome, Obsessive Compulsive Disorder, Schizophrenia, Depression, Cluster C Traits. The POS documents that R18 has medications which include: Ativan 1 mg (Milligram) intramuscularly injection to be given every six hours as needed for 72 hours dated 8-08-13, Risperidone 2 mg three times daily, Lamictal 100 mg two times daily, Klonopin 1 mg three times daily. The POS also included an order for Ativan 1 mg intramuscularly injection given as a now dose on dated 8-02-13.

A Minimum Data Set (MDS) Assessment, dated 6-20-13, documents that R18 is moderately cognitively impaired, independently mobile, and displayed verbal behavioral symptoms directed

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toward others four to six days per week. The MDS documents that R18's behaviors, "Put others at significant risk for physical injury...Significantly disrupt care or living environment."
Nurse's Notes, dated 9/2012 through 12/2012, document that the first incident of R18, "trying to hit another resident," was 12-03-12. The remaining Nurse's Notes, dated 12/2012 to 8/2013, document multiple, frequent incidents of R18 hitting or attempting to hit facility staff and residents, entering resident rooms uninvited, throwing dishes, kicking, or attempting to hit others with R18's walker.
A facility incident report, dated 12-19-12, documents that R18 was, "hitting and kicking staff with closed hand and other residents." The incident report also indicates that R18 was witnessed kicking E27 (Registered Nurse). The incident report documents that R18 was removed, "from hostile environment to prevent harm from self and others."
A facility incident report, dated 3-18-13 documents that, "Another resident (R18) hit R39 on the back of the neck for no reason... R39 was sitting in reclining wheel chair in dining room." The incident report documents that, "Staff (counseled) on keeping R18 away from the other resident (R39) as much as possible and monitor closely when they are in the same room." A second incident report for the same incident, dated 3-19-13, documents that R18 also was attempting to, "kick another staff and resident." The incident report documented E 28 (Certified Nurse Aide), "Was in the dining area and resident hit at me twice and tried to kick me..."
A facility incident report, dated 8-12-13, documents that R18, "Entered another resident's room (R21) and struck R21 on the left forearm for

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an unknown reason. When asked why R18 did it, R18 said, 'I had to,' Neither resident was injured."
The incident report indicates that the "recommended steps to prevent recurrence" included, "R18 had recent med increase. R18 is to be redirected when going down hall and kept from going into others rooms without permission. When R18 is having behaviors redirect to R18's room or the nearest quiet place. Resident on 30 minute checks."
A facility incident report dated 8-13-13 documents that, "E14 (Assistant Director of Nurses) observed R18 running into another resident (R28) unintentionally with R18's walker pushing R28 up against the wall...(R18) also approached E14 in the medication room and struck E14 on the left wrist with R18's hand."
A care plan dated 9-13-12 documents that R18, "...has a history of verbal and physical aggression...R18 does not like to be touched...hits staff, throws trays." R18's behavior care plan interventions include: "explain R18 cannot use physical aggression and the importance of not being verbally or physically aggressive to anyone." The care plan also includes the intervention of providing, "1 to 1" supervision for R18 "Daily and as needed."
On 8-13-13 at 11:30 AM. R18 was in the hallway in front of the nurse's station. R18 was yelling unintelligibly while pushing R28 against the wall with a walker. E14 (Assistant Director of Nurses) approached R18 and loudly stated to R18, Don't do that." and led R18 down the hall towards R18's room.
On 8-14-13 at 9:05 AM. R21 stated that on 8-12-13 R18 entered R21's room and hit R21 in the arm. R21 stated that R18 has hit R21 at least four to five times in the past. R21 stated, "(R18) just rams me with the walker hard enough that if I

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was using my cane I would have gone down." R21 stated that, "(R18) is far too dangerous." R21 stated that when R18 hit R21 on the arm facility staff removed R18 from R21's room while at the same time telling R18, "(R18) couldn't get any pudding or something." R21 stated, "I do everything to avoid (R18) but (R18) comes up behind me. (R18) lives right by me and (R18) will see me come out of my room then (R18) will come right out and come after me" R21 stated, "I'm 64 years old and I've never been bullied until now."

On 8-14-13 at 11:00 AM. E9 (Registered Nurse), E16, and E17 (Certified Nurse Aides) were at the nurses station. E9 stated that R18's behaviors had increased recently but that R18's behaviors were actually just getting back to normal now that R18's medical problems were improving. E17 stated that R18 had hit E2 (Director of Nurses)and E17 on 8-09-13 and had hit E17 also on 8-13-13. E17 stated, "(R18) got E2 last Friday and got me last Friday too. (R18) got me yesterday too." E17 stated, "Back about a month ago (R18) came up behind me and hit me on my back." E16 stated, "(R18)threw a walker at my back and on 8-09-13, (R18) came from behind and tried to hit me on my back." E16 stated, "And he tried to choke me." E16 stated that the incident had not been documented on an incident report because, "I knew that was just his behavior." E9 stated that some of R18's behaviors were because R18 wanted chocolate pudding stating, "I just walk R18 back to R18's room and give R18 what R18 wants."

On 8-14-13 at 2:55 PM. E14 (Assistant Director of Nurse's) stated that when R18 becomes agitated, threatens to hit or kick, or actually hits or kicks staff and residents, R18 is redirected to R18's room. E14 stated that R18, "gets better for

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awhile then gets aggressive. (R18) doesn't pick his people, it's just anyone who is near. (R18) will say, 'I need to hit you."
R17's Nurse's Notes dated 8/12/13 at 5:50 p.m. document "it was brought to my attention a softball size lump had appeared on R17's left upper chest. It was not there during 2:30 p.m. rounds." The Nurse's Note at 7:15 p.m. documents "now bruised and appeared larger." R17's note at 7:15 p.m. documents "now bruised and appeared larger. send to emergency for evaluation, possible fractured rib."

R17's Resident Transfer Form from the facility to the emergency room, dated 8/12/13 at 5:50 p.m., documents " injury of unknown origin, left upper chest, soft ball sized bump."

R17's Preliminary Field Medical Report, dated 8/12/13, documents "hematoma above left nipple, bruise." R17's Emergency Transport Patient Care Report documents "large hematoma above left nipple, contusions and bruising all over body." The form documents chest, upper left arm and upper left leg as "soft tissue swelling and bruising." This form also documents under the Narrative section "(R17) was found laying in bed in the facility. "large edematous lump above left nipple up to shoulder about the size of a baseball. Patient (R17) also has bruising to his left upper arm and all across his chest. There is also bruising noted on legs. RN (Registered Nurse) stated being unsure of what happened to the patient but whatever occurred must have happened between 2 PM and 5 p.m. that day (8/12/13)."

R17's Summary of Current Hospitalization Emergency Room Note, dated 8/12/13,

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documents R17 was admitted from the facility with left chest hematoma. It also documents, "The emergency room staff contacted elder abuse hotline due to multiple ecchymotic(bruising) areas to skin and concern for abuse." Under the section of this form titled Assessment it documents "left chest hematoma, uncertain etiology, multiple bruises on body, social services following regarding potential elder abuse." R17's hospital record documents "5 inch diameter hematoma on left anterior chest. Ecchymosis (bruising) in left axillary region. Ecchymosis on right anterior chest wall. Multiple small lesions over legs." On 8/13/13 at 9:22 AM, Z2 (Admitting Emergency Room Physician) confirmed that the above-referenced note accurately represents R17's condition on admission to the Emergency Room.

On 8/13/13 at 11:45 AM, R17 was unable to respond appropriately to questions and just repeated "yes." R17 had a softball size raised area on R17's left upper chest. R17 had dark purple bruising in the left axilla which extended down to the elbow. R17's entire left bicep area was bruised. R17 had scattered bruising all the way across the chest just below the nipple line. R17's left foot had purple bruising starting at the left great toe and extending up the length of the foot about 1 1/2-2 inches wide. R17 had a pea sized scabbed area on the left great toe and left knee.

On 8/13/13 at 12:45 p.m. E13 (Nurse) stated that on 8/12/13 at 2:30 p.m. R17 was fine but when E15/CNA (Certified Nursing Assistant) got R17 up for dinner is when a red flat areas were

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discovered on R17's left chest, "don't know what it was, no one heard any noise or commotion from R17 and R18's room." E13 stated E2 (Director of Nursing) instructed E13 to chart the red area as an injury of unknown origin. E13 stated after dinner E13 reexamined R17 and found the red area to be bruised. E13 stated being "at loss as to what happened to R17."

On 8/13/13 a signed statement by E15 CNA (Certified Nursing Assistant) documented on 8/12/13 at 5:30 p.m. E15 went to get R17 up for dinner and noticed a large bump on R17's left chest. E15 asked R17 what happened and R17 stated "(R18) been hitting me."

On 8/14/13 at 11:00 a.m. E16/CNA stated the following: Last Friday (8/9/13), between 9:45 a.m. and 10:00 a.m., E13 (Nurse) asked for help because R18 was in his room fighting with R17. E16 saw R18 hit R17. E13 (Nurse) directed E16 to get R17 up and out of his room because R18 was hitting R17 in his chest. E16 started getting R17 up and E13 had to hold R18 back so the staff could get R17 up. E13 also saw R18 hit R17.

On 8/14/13 at 11:00 a.m. E9/LPN (Licensed Practical Nurse) stated the following: Last Friday (8/9/13) E13 (Nurse) had staff get R17 up and out of is room because R18 was hitting R17 in the chest. E9 saw R18 hit R17. E13 (Nurse) asked for help because R18 was fighting with R17 and E13 had to hold R18 so staff could get R17 up.

2. R23's POS dated 3-1-13, documents R23 had diagnoses of Impulse Control, and Mood Disorder. R23 was discharged from the facility on 7-7-13.

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R23's Nurse's Notes, dated 12-21-12 at 2:45 a.m., document R23 hit R40 in the mouth because R40 took R23's radio and ate R23's food. The accident report does not include interventions to prevent a recurrence of R23's behaviors.

R23's nurse's notes dated 1-8-13 at 8:00 a.m., document R23 was "yelling and telling people to get out of the room."

A facility report dated 3-26-13 at 9:43 a.m. and signed by E2 (Director of Nursing), documents on 3-25-13 at 5:45 p.m., R13, who has a diagnosis of Senile Dementia, walked into R23's room. R23 became upset because R13 entered the room and R23 pushed R13 down to the floor. R13 was sent to the emergency room for complaints of right hip pain. R13's pelvis and right hip x-ray dated 3-25-13, documents R13 had two acute fractures of the pelvis. The facility report documents R23 was ticketed for battery and given a notice to appear in court.

R23's Nurse's Notes, dated 3-25-13 at 5:45 p.m., document R23 "got mad" because another resident came into R23's room, and R23 pushed the resident (R13) down. The 3-25-13 Nurse's Notes document R23 felt no remorse and R23 stated, "No one should come into my room."

On 8-14-13 at 9:15 a.m., E6 (CNA) stated R23 would curse and fight with staff and residents almost everyday. E6 stated the residents were scared of R23.

On 8-14-13 at 10:30 a.m., E9 (Licensed Practical Nurse/LPN) stated R23 was physically and verbally abusive to residents and staff. R23

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stated if other residents entered R23's room, R23 would push the residents out of the room and throw things at them.

On 8-15-13 at 1:15 p.m., E26 (Social Rehabilitation Worker) stated R23's interventions to deal with behaviors were talking with R23 and telling R23 "you can't hurt people." E26 stated "I was unaware of (R23) ever hitting other residents." E26 stated no new interventions were implemented on R23's care plan when R23 was verbally and physically aggressive towards R40 on 12-21-12 or towards R13 on 3-25-13.

On 8-13-13 at 2:40 p.m., E1/Administrator stated R23 was known to not like other residents in R23's room or space.

On 8-13-13 at 11:10 AM, E1 stated that none of the incidents listed above were reported or investigated as abuse because the incidents were due to "behaviors"

On 08/14/13 at 1:00 p.m. an Immediate Jeopardy was identified to have begun on 12-03-12 when R18 was identified as having assualtive behaviors towards other residents. On 08/14/13 at 1:15 p.m. E1/Administrator was notified of the Immediate Jeopardy.

The surveyor confirmed through record review and interview that the facility took the following actions to remove the Immediate Jeopardy:

1) Amendment of the facility Abuse Policy to reflect throughout the policy that the facility Administrator will be notified immediately if there is a suspected case of abuse. This same policy also includes notification of state agency

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F 223	Continued From page 12 (IDPH) as soon as possible. 2) Education of staff on policy changes and expectations of all staff members with regard to notifying Administrator and IDPH of suspected abuse. 3) R18 has been removed from the building and admitted for a psychiatric evaluation. A notice of immediate discharge has been given. 4) Facility form to include a mechanism of staff reporting for the person suspecting abuse to fill out and give to the approprate person in charge at the time of the suspected abuse. Education of staff on this form was completed. 5) Establishment of an Abuse Prevention Compliance Committee who will meet after every suspected allegation of abuse and is responsible for gathering all information, interview, investigation and reporting of their findings to the Administrator. Effective 08/14/13. 6) New form for notification of IDPH. One form will be an initial report form that will be used to do the inital notification to the deparment while the other form is for notification of the final results of the investigation.. Effective 08/14/13. 7) Prescreening of all potential residents by the IDT (Interdisciplinary Team) prior to admission to determine the risk to abuse/be abused. 8) Immediate care planning of all residents with the potential to be abused. 9) Risk assessment for abuse is to be done on all current residents. An aggression and violence screening form will also be completed. Any deficits identified in these areas will be addressed on the residents care plan to maintain safety for all residents. Completion date 08/21/13.	F 223		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 13 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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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I. Based on observation, interview and record review the facility failed to recognize the physically aggressive behaviors of four residents, R18, R23, R32 and R38, as abuse, resulting in further failure by the facility to do the following:
A.Failure to protect three of three (R13, R17 and R21) residents who were victims of aggression on the sample of 17 and three residents who were victims of aggression (R28, R39 and R40) on the supplemental sample;
B.Failure to investigate incidents of aggression or injury of unknown origin for three of three residents (R13, R17 and R21) who were victims of aggression on the sample of 17 and seven residents (R28, R31, R33 ,R34, R37, R39 and R40) on the supplemental sample; and
C.Failure to report abuse or injuries of unknown origin to the facility administrator and state agency immediately for three of three residents (R13, R17 and R21) who were victims of aggression on the sample of 17 and seven residents (R28, R31, R33 ,R34, R37, R39 and R40) on the supplemental sample.
These failures resulted in immediate jeopardy. While the immediate jeopardy was removed on 8-14-13, the facility remains out of compliance at severity level two. Additional time is need to monitor the effectiveness of the inservices conducted.
Based on interview and record review, the facility also failed to report missing narcotic medications to the state agency for one of one incidents involving missing medications.

Findings include:
1.R23's POS dated 3-1-13, documents R23 had diagnoses of Impulse Control, and Mood Disorder. R23 was discharged from the facility on 7-7-13.

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R23's Nurse's Notes, dated 12-21-12 at 2:45 a.m., document R23 hit R40 in the mouth because R40 took R23's radio and ate R23's food. The accident report does not include interventions to prevent a recurrence of R23's behaviors.

R23's nurse's notes dated 1-8-13 at 8:00 a.m., document R23 was "yelling and telling people to get out of the room."

A facility report dated 3-26-13 at 9:43 a.m. and signed by E2 (Director of Nursing), documents on 3-25-13 at 5:45 p.m., R13, who has a diagnosis of Senile Dementia, walked into R23's room. R23 became upset because R13 entered the room and R23 pushed R13 down to the floor. R13 was sent to the emergency room for complaints of right hip pain. R13's pelvis and right hip x-ray dated 3-25-13, documents R13 had two acute fractures of the pelvis. The facility report documents R23 was ticketed for battery and given a notice to appear in court.

R23's Nurse's Notes, dated 3-25-13 at 5:45 p.m., document R23 "got mad" because another resident came into R23's room, and R23 pushed the resident (R13) down. The 3-25-13 Nurse's Notes document R23 felt no remorse and R23 stated, "No one should come into my room."

On 8-14-13 at 9:15 a.m., E6 (CNA) stated R23 would curse and fight with staff and residents almost everyday. E6 stated the residents were scared of R23.

On 8-14-13 at 10:30 a.m., E9 (Licensed Practical Nurse/LPN) stated R23 was physically and

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verbally abusive to residents and staff. R23 stated if other residents entered R23's room, R23 would push the residents out of the room and throw things at them.

On 8-15-13 at 1:15 p.m., E26 (Social Rehabilitation Worker) stated R23's interventions to deal with behaviors were talking with R23 and telling R23 "you can't hurt people." E26 stated "I was unaware of (R23) ever hitting other residents." E26 stated no new interventions were implemented on R23's care plan when R23 was verbally and physically aggressive towards R40 on 12-21-12 or towards R13 on 3-25-13.

On 8-13-13 at 2:40 p.m., E1/Administrator stated R23 was known to not like other residents in R23's room or space.

2. A physician's order sheet (POS) dated, 8/2013, documents that R18 has diagnoses which include: Asperger's Syndrome, Obsessive Compulsive Disorder, Schizophrenia, Depression, Cluster C Traits. The POS documents that R18 has medications which include: Ativan 1 mg (Milligram) intramuscularly injection to be given every six hours as needed for 72 hours dated 8-08-13, Risperidone 2 mg three times daily, Lamictal 100 mg two times daily, Klonopin 1 mg three times daily. The POS also included an order for Ativan 1 mg intramuscularly injection given as a now dose on dated 8-02-13.
A Minimum Data Set (MDS) Assessment, dated 6-20-13, documents that R18 is moderately cognitively impaired, independently mobile, and displayed verbal behavioral symptoms directed toward others four to six days per week. The MDS documents that R18's behaviors, "Put others at significant risk for physical

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injury...Significantly disrupt care or living environment."
Nurse's Notes, dated 9/2012 through 12/2012, document that the first incident of R18, "trying to hit another resident," was 12-03-12. The remaining Nurse's Notes, dated 12/2012 to 8/2013, document multiple, frequent incidents of R18 hitting or attempting to hit facility staff and residents, entering resident rooms uninvited, throwing dishes, kicking, or attempting to hit others with R18's walker.
A facility incident report, dated 12-19-12, documents that R18 was, "hitting and kicking staff with closed hand and other residents." The incident report also indicates that R18 was witnessed kicking E27 (Registered Nurse). The incident report documents that R18 was removed, "from hostile environment to prevent harm from self and others."
A facility incident report, dated 3-18-13 documents that, "Another resident (R18) hit R39 on the back of the neck for no reason... R39 was sitting in reclining wheel chair in dining room." The incident report documents that, "Staff (counseled) on keeping R18 away from the other resident (R39) as much as possible and monitor closely when they are in the same room." A second incident report for the same incident, dated 3-19-13, documents that R18 also was attempting to, "kick another staff and resident." The incident report documented E 28 (Certified Nurse Aide), "Was in the dining area and resident hit at me twice and tried to kick me..."
A facility incident report, dated 8-12-13, documents that R18, "Entered another resident's room (R21) and struck R21 on the left forearm for an unknown reason. When asked why R18 did it, R18 said, 'I had to,' Neither resident was injured." The incident report indicates that the

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"recommended steps to prevent recurrence" included, "R18 had recent med increase. R18 is to be redirected when going down hall and kept from going into others rooms without permission. When R18 is having behaviors redirect to R18's room or the nearest quiet place. Resident on 30 minute checks."

A facility incident report dated 8-13-13 documents that, "E14 (Assistant Director of Nurses) observed R18 running into another resident (R28) unintentionally with R18's walker pushing R28 up against the wall...(R18) also approached E14 in the medication room and struck E14 on the left wrist with R18's hand."

A care plan dated 9-13-12 documents that R18, "...has a history of verbal and physical aggression...R18 does not like to be touched...hits staff, throws trays." R18's behavior care plan interventions include: "explain R18 cannot use physical aggression and the importance of not being verbally or physically aggressive to anyone." The care plan also includes the intervention of providing, "1 to 1" supervision for R18 "Daily and as needed."

On 8-13-13 at 11:30 AM. R18 was in the hallway in front of the nurse's station. R18 was yelling unintelligibly while pushing R28 against the wall with a walker. E14 (Assistant Director of Nurses) approached R18 and loudly stated to R18, Don't do that." and led R18 down the hall towards R18's room.

On 8-14-13 at 9:05 AM. R21 stated that on 8-12-13 R18 entered R21's room and hit R21 in the arm. R21 stated that R18 has hit R21 at least four to five times in the past. R21 stated, "(R18) just rams me with the walker hard enough that if I was using my cane I would have gone down." R21 stated that, "(R18) is far too dangerous." R21 stated that when R18 hit R21 on the arm

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facility staff removed R18 from R21's room while at the same time telling R18, "(R18) couldn't get any pudding or something." R21 stated, "I do everything to avoid (R18) but (R18) comes up behind me. (R18) lives right by me and (R18) will see me come out of my room then (R18) will come right out and come after me" R21 stated, "I'm 64 years old and I've never been bullied until now."

On 8-14-13 at 11:00 AM. E9 (Registered Nurse), E16, and E17 (Certified Nurse Aides) were at the nurses station. E9 stated that R18's behaviors had increased recently but that R18's behaviors were actually just getting back to normal now that R18's medical problems were improving. E17 stated that R18 had hit E2 (Director of Nurses)and E17 on 8-09-13 and had hit E17 also on 8-13-13. E17 stated, "(R18) got E2 last Friday and got me last Friday too. (R18) got me yesterday too." E17 stated, "Back about a month ago (R18) came up behind me and hit me on my back." E16 stated, "(R18)threw a walker at my back and on 8-09-13, (R18) came from behind and tried to hit me on my back." E16 stated, "And he tried to choke me." E16 stated that the incident had not been documented on an incident report because, "I knew that was just his behavior." E9 stated that some of R18's behaviors were because R18 wanted chocolate pudding stating, "I just walk R18 back to R18's room and give R18 what R18 wants."

On 8-14-13 at 2:55 PM. E14 (Assistant Director of Nurse's) stated that when R18 becomes agitated, threatens to hit or kick, or actually hits or kicks staff and residents, R18 is redirected to R18's room. E14 stated that R18, "gets better for awhile then gets aggressive. (R18) doesn't pick his people, it's just anyone who is near. (R18) will say, 'I need to hit you."

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R17's Nurse's Notes dated 8/12/13 at 5:50 p.m. document "it was brought to my attention a softball size lump had appeared on R17's left upper chest. It was not there during 2:30 p.m. rounds." The Nurse's Note at 7:15 p.m. documents "now bruised and appeared larger." R17's note at 7:15 p.m. documents "now bruised and appeared larger. send to emergency for evaluation, possible fractured rib."

R17's Resident Transfer Form from the facility to the emergency room, dated 8/12/13 at 5:50 p.m., documents " injury of unknown origin, left upper chest, soft ball sized bump."

R17's Preliminary Field Medical Report, dated 8/12/13, documents "hematoma above left nipple, bruise." R17's Emergency Transport Patient Care Report documents "large hematoma above left nipple, contusions and bruising all over body." The form documents chest, upper left arm and upper left leg as "soft tissue swelling and bruising." This form also documents under the Narrative section "(R17) was found laying in bed in the facility. "large edematous lump above left nipple up to shoulder about the size of a baseball. Patient (R17) also has bruising to his left upper arm and all across his chest. There is also bruising noted on legs. RN (Registered Nurse) stated being unsure of what happened to the patient but whatever occurred must have happened between 2 PM and 5 p.m. that day (8/12/13)."

R17's Summary of Current Hospitalization Emergency Room Note, dated 8/12/13, documents R17 was admitted from the facility with left chest hematoma. It also documents, "The emergency room staff contacted elder

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abuse hotline due to multiple ecchymotic(bruising) areas to skin and concern for abuse." Under the section of this form titled Assessment it documents "left chest hematoma, uncertain etiology, multiple bruises on body, social services following regarding potential elder abuse." R17's hospital record documents "5 inch diameter hematoma on left anterior chest. Ecchymosis (bruising) in left axillary region. Ecchymosis on right anterior chest wall. Multiple small lesions over legs." On 8/13/13 at 9:22 AM, Z2 (Admitting Emergency Room Physician) confirmed that the above-referenced note accurately represents R17's condition on admission to the Emergency Room.

On 8/13/13 at 11:45 AM, R17 was unable to respond appropriately to questions and just repeated "yes." R17 had a softball size raised area on R17's left upper chest. R17 had dark purple bruising in the left axilla which extended down to the elbow. R17's entire left bicep area was bruised. R17 had scattered bruising all the way across the chest just below the nipple line. R17's left foot had purple bruising starting at the left great toe and extending up the length of the foot about 1 1/2-2 inches wide. R17 had a pea sized scabbed area on the left great toe and left knee.

On 8/13/13 at 12:45 p.m. E13 (Nurse) stated that on 8/12/13 at 2:30 p.m. R17 was fine but when E15/CNA (Certified Nursing Assistant) got R17 up for dinner is when a red flat areas were discovered on R17's left chest, "don't know what it was, no one heard any noise or commotion from R17 and R18's room." E13 stated E2

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(Director of Nursing) instructed E13 to chart the red area as an injury of unknown origin. E13 stated after dinner E13 reexamined R17 and found the red area to be bruised. E13 stated being "at loss as to what happened to R17."

On 8/13/13 a signed statement by E15 CNA (Certified Nursing Assistant) documented on 8/12/13 at 5:30 p.m. E15 went to get R17 up for dinner and noticed a large bump on R17's left chest. E15 asked R17 what happened and R17 stated "(R18) been hitting me."

On 8/14/13 at 11:00 a.m. E16/CNA stated the following: Last Friday (8/9/13), between 9:45 a.m. and 10:00 a.m., E13 (Nurse) asked for help because R18 was in his room fighting with R17. E16 saw R18 hit R17. E13 (Nurse) directed E16 to get R17 up and out of his room because R18 was hitting R17 in his chest. E16 started getting R17 up and E13 had to hold R18 back so the staff could get R17 up. E13 also saw R18 hit R17.

On 8/14/13 at 11:00 a.m. E9/LPN (Licensed Practical Nurse) stated the following: Last Friday (8/9/13) E13 (Nurse) had staff get R17 up and out of is room because R18 was hitting R17 in the chest. E9 saw R18 hit R17. E13 (Nurse) asked for help because R18 was fighting with R17 and E13 had to hold R18 so staff could get R17 up.

On 8-13-13 at 11:10 AM, E1 stated that none of the incidents listed above in examples 1 and 2 were reported or investigated as abuse because the incidents were due to "behaviors".

3. A facility incident report dated 6/9/13 at 7:30 PM documents R33 was found on the floor

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unresponsive with a laceration to the left eye. R33 was sent to the hospital and found to have a Intercranial Hemorrhage. E1 did not sign the form until 6/10/13. IDPH was not notified until 6/10/13 at 9:43 a.m.

O8-13-13 at 11:10 AM, E1 stated that this injury of unknown origin was not investigated as possible abuse.

4. R31's incident report dated 3/1/13 at 3:45 p.m. documents R31 was noted to have swelling and bruising to the 4th finger on the left hand which was later found to be fractured. The incident report under the section titled "describe exactly what you observed or heard" documented "unable to make statement clear, stated she sleeps and had nightmares and that is how it happened, no witnesses." R31's Physician order sheet dated 8/1/13 documents R31 has Disorganized type Schizophrenia and Dementia. R31's history and physical documents R31 has delusions, hallucinations, poor judgement, poor memory, verbal aggression and flight of ideas. An abuse investigation was not completed. E1 (Administrator) signed the incident form on 3/4/13. The incident form was faxed to IDPH 3/4/13, 3 days after the injury of unknown origin occurred.

On 8/13/13 at 11:10 a.m. E1 (Administrator) stated E1 did not investigate this bruising and swelling as abuse because "you just have to know her (R31)."

5. A facility incident report dated 5/1/13 documents R32 punched R 34 in the head 3 times and then R32 pushed R34's wheelchair causing the wheelchair to propel. R32's history

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and physical documents R32 has a history of verbal and physical aggression and of making false accusations. R32 ' s care plan includes no documentation of review or new intervention after the 5-1-13 incident. An abuse investigation was not initiated. The incident form was not signed by E1 and IDPH was not notified until 5/2/13, 1 day later.

On 8/13/13 at 11:10 a.m. E1 confirmed that the incident was not reported or investigated as abuse and stated "well, they are boyfriend and girlfriend."

6. A facility incident report dated 6/18/13 at 1:00 p.m. documents R38 grabbed R37's walker, R37 then struck R38 in the eye. R38 then threw water on R37. E1 ' s signature on the incident report form is dated 6/19/13. IDPH was notified of the incident via fax on 6/19/13 at 10:10 a.m.

The care plan for R38 includes no documentation of review or new intervention after the 6-18-13 incident.

On 8/13/13 at 11:10 a.m. E1 confirmed that the incident was not reported or investigated as abuse.

On 08/14/13 at 1:00 PM an Immediate Jeopardy was identified to have begun on 12-03-12 when R18 was identified as having assualtive behaviors towards other residents. On 08/14/13 at 1:15PM E1/Administrator was notified of the Immediate Jeopardy.

The surveyor confirmed through record review and interview that the facility took the following actions to remove the Immediate Jeopardy:

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1) Amendment of the facility Abuse Policy to reflect throughout the policy that the facility Administrator will be notified immediately if there is a suspected case of abuse. This same policy also includes notification of state agency (IDPH) as soon as possible.
2) Education of staff on policy changes and expectations of all staff members with regard to notifying Administrator and IDPH of suspected abuse.
3)R18 has been removed from the building and admitted for a psychiatric evaluation. A notice of immediate discharge has been given.
4) Facility form to include a mechanism of staff reporting for the person suspecting abuse to fill out and give to the approprate person in charge at the time of the suspected abuse. Education of staff on this form was completed.
5) Establishment of an Abuse Prevention Compliance Committee who will meet after every suspected allegation of abuse and is responsible for gathering all information, interview, investigation and reporting of their findings to the Administrator. Effective 08/14/13.
6) New form for notification of IDPH. One form will be an initial report form that will be used to do the inital notification to the deparment while the other form is for notification of the final results of the investigation.. Effective 08/14/13.
7) Prescreening of all potential residents by the IDT (Interdisciplinary Team) prior to admission to determine the risk to abuse/be abused.
8) Immediate care planning of all residents with the potential to be abused.
9) Risk assessment for abuse is to be done on all current residents. An aggression and violence screening form will also be completed. Any deficits identified in these areas will be addressed

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F 225	Continued From page 26 on the residents care plan to maintain safety for all residents. Completion date 08/21/13. The Facility's investigation narrative documents the missing Lortab investigation was initiated on 7/1/13. The investigation documents on 6/30/13 the narcotic count for Lortab was incorrect and it was reported to E2 DON. On 8/21/13 E1 (Administrator) stated about 1 month ago Lortab (Hydrocodone) came up missing from a medication cart. E1 stated around the same time there was a question about liquid Morphine due to 2 different colored bottles. E1 stated at that time E1 decided to involve the state police and have the state police come into the facility to complete an investigation. E1 stated the State Police interviewed and investigated.. E1 stated the medication incident was not reported to the state agency. On 8/21/13 at 1:20 p.m. E2 DON (Director of Nursing) stated the suspected missing medications were not reported to the state agency.	F 225		
F 226 SS=K	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:	F 226		

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Based on interview and record review the facility failed to investigate and report all allegations of suspected abuse and injury of unknown origin immediately to the administrator and state agency as required by facility policy for three of four residents (R13, R17, R21) reviewed for abuse in the sample of 17 and eight residents in the supplemental sample (R28, R31, R33, R34, R37, R38, R39 R40).

These failures resulted in immediate jeopardy. While the immediate jeopardy was removed on 8/14/13, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the inservices conducted.

1.R23's Nurse's Notes, dated 12-21-12 at 2:45 a.m., document R23 hit R40 in the mouth because R40 took R23's radio and ate R23's food. The accident report does not include interventions to prevent a recurrence of R23's behaviors.

A facility report dated 3-26-13 at 9:43 a.m. and signed by E2 (Director of Nursing), documents on 3-25-13 at 5:45 p.m., R13, who has a diagnosis of Senile Dementia, walked into R23's room. R23 became upset because R13 entered the room and R23 pushed R13 down to the floor. R13 was sent to the emergency room for complaints of right hip pain. R13's pelvis and right hip x-ray dated 3-25-13, documents R13 had two acute fractures of the pelvis. The facility report documents R23 was ticketed for battery and given a notice to appear in court.

R23's Nurse's Notes, dated 3-25-13 at 5:45 p.m., document R23 "got mad" because another

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resident came into R23's room, and R23 pushed the resident (R13) down. The 3-25-13 Nurse's Notes document R23 felt no remorse and R23 stated, "No one should come into my room."

On 8-13-13 at 2:40 p.m., E1/Administrator stated R23 was known to not like other residents in R23's room or space.

2. A facility incident report, dated 3-18-13 documents that, "Another resident (R18) hit R39 on the back of the neck for no reason... R39 was sitting in reclining wheel chair in dining room." The incident report documents that, "Staff (counseled) on keeping R18 away from the other resident (R39) as much as possible and monitor closely when they are in the same room." A second incident report for the same incident, dated 3-19-13, documents that R18 also was attempting to, "kick another staff and resident." The incident report documented E 28 (Certified Nurse Aide), "Was in the dining area and resident hit at me twice and tried to kick me..."
A facility incident report, dated 8-12-13, documents that R18, "Entered another resident's room (R21) and struck R21 on the left forearm for an unknown reason. When asked why R18 did it, R18 said, 'I had to,' Neither resident was injured." The incident report indicates that the "recommended steps to prevent recurrence" included, "R18 had recent med increase. R18 is to be redirected when going down hall and kept from going into others rooms without permission. When R18 is having behaviors redirect to R18's room or the nearest quiet place. Resident on 30 minute checks."
A facility incident report dated 8-13-13 documents that, "E14 (Assistant Director of Nurses)

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observed R18 running into another resident (R28) unintentionally with R18's walker pushing R28 up against the wall...(R18) also approached E14 in the medication room and struck E14 on the left wrist with R18's hand."
On 8-13-13 at 11:30 AM. R18 was in the hallway in front of the nurse's station. R18 was yelling unintelligibly while pushing R28 against the wall with a walker. E14 (Assistant Director of Nurses) approached R18 and loudly stated to R18, Don't do that." and led R18 down the hall towards R18's room.
On 8-14-13 at 9:05 AM. R21 stated that on 8-12-13 R18 entered R21's room and hit R21 in the arm. R21 stated that R18 has hit R21 at least four to five times in the past. R21 stated, "(R18) just rams me with the walker hard enough that if I was using my cane I would have gone down." R21 stated that, "(R18) is far too dangerous." R21 stated that when R18 hit R21 on the arm facility staff removed R18 from R21's room while at the same time telling R18, "(R18) couldn't get any pudding or something." R21 stated, "I do everything to avoid (R18) but (R18) comes up behind me. (R18) lives right by me and (R18) will see me come out of my room then (R18) will come right out and come after me" R21 stated, "I'm 64 years old and I've never been bullied until now."
R17's Nurse's Notes dated 8/12/13 at 5:50 p.m. document "it was brought to my attention a softball size lump had appeared on R17's left upper chest. It was not there during 2:30 p.m. rounds." The Nurse's Note at 7:15 p.m. documents "now bruised and appeared larger." R17's note at 7:15 p.m. documents "now bruised and appeared larger. send to emergency for evaluation, possible fractured rib."

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R17's Resident Transfer Form from the facility to the emergency room, dated 8/12/13 at 5:50 p.m., documents " injury of unknown origin, left upper chest, soft ball sized bump."

R17's Preliminary Field Medical Report, dated 8/12/13, documents "hematoma above left nipple, bruise." R17's Emergency Transport Patient Care Report documents "large hematoma above left nipple, contusions and bruising all over body." The form documents chest, upper left arm and upper left leg as "soft tissue swelling and bruising." This form also documents under the Narrative section "(R17) was found laying in bed in the facility. "large edematous lump above left nipple up to shoulder about the size of a baseball. Patient (R17) also has bruising to his left upper arm and all across his chest. There is also bruising noted on legs. RN (Registered Nurse) stated being unsure of what happened to the patient but whatever occurred must have happened between 2 PM and 5 p.m. that day (8/12/13)."

R17's Summary of Current Hospitalization Emergency Room Note, dated 8/12/13, documents R17 was admitted from the facility with left chest hematoma. It also documents, "The emergency room staff contacted elder abuse hotline due to multiple ecchymotic(bruising) areas to skin and concern for abuse." Under the section of this form titled Assessment it documents "left chest hematoma, uncertain etiology, multiple bruises on body, social services following regarding potential elder abuse." R17's hospital record documents "5 inch diameter hematoma on left anterior chest. Ecchymosis (bruising) in left axillary region. Ecchymosis on right anterior chest wall. Multiple

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small lesions over legs." On 8/13/13 at 9:22 AM, Z2 (Admitting Emergency Room Physician) confirmed that the above-referenced note accurately represents R17's condition on admission to the Emergency Room.

On 8/13/13 at 11:45 AM, R17 was unable to respond appropriately to questions and just repeated "yes." R17 had a softball size raised area on R17's left upper chest. R17 had dark purple bruising in the left axilla which extended down to the elbow. R17's entire left bicep area was bruised. R17 had scattered bruising all the way across the chest just below the nipple line. R17's left foot had purple bruising starting at the left great toe and extending up the length of the foot about 1 1/2-2 inches wide. R17 had a pea sized scabbed area on the left great toe and left knee.

On 8/13/13 at 12:45 p.m. E13 (Nurse) stated that on 8/12/13 at 2:30 p.m. R17 was fine but when E15/CNA (Certified Nursing Assistant) got R17 up for dinner is when a red flat areas were discovered on R17's left chest, "don't know what it was, no one heard any noise or commotion from R17 and R18's room." E13 stated E2 (Director of Nursing) instructed E13 to chart the red area as an injury of unknown origin. E13 stated after dinner E13 reexamined R17 and found the red area to be bruised. E13 stated being "at loss as to what happened to R17."

On 8/13/13 a signed statement by E15 CNA (Certified Nursing Assistant) documented on 8/12/13 at 5:30 p.m. E15 went to get R17 up for dinner and noticed a large bump on R17's left

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chest. E15 asked R17 what happened and R17 stated "(R18) been hitting me."

On 8/14/13 at 11:00 a.m. E16/CNA stated the following: Last Friday (8/9/13), between 9:45 a.m. and 10:00 a.m., E13 (Nurse) asked for help because R18 was in his room fighting with R17. E16 saw R18 hit R17. E13 (Nurse) directed E16 to get R17 up and out of his room because R18 was hitting R17 in his chest. E16 started getting R17 up and E13 had to hold R18 back so the staff could get R17 up. E13 also saw R18 hit R17.

On 8/14/13 at 11:00 a.m. E9/LPN (Licensed Practical Nurse) stated the following: Last Friday (8/9/13) E13 (Nurse) had staff get R17 up and out of is room because R18 was hitting R17 in the chest. E9 saw R18 hit R17. E13 (Nurse) asked for help because R18 was fighting with R17 and E13 had to hold R18 so staff could get R17 up.

On 8-13-13 at 11:10 AM, E1 stated that none of the incidents listed above in examples 1 and 2 were reported or investigated as abuse because the incidents were due to "behaviors".

3. A facility incident report dated 6/9/13 at 7:30 PM documents R33 was found on the floor unresponsive with a laceration to the left eye. R33 was sent to the hospital and found to have a Intercranial Hemorrhage. E1 did not sign the form until 6/10/13. IDPH was not notified until 6/10/13 at 9:43 a.m.

O8-13-13 at 11:10 AM, E1 stated that this injury of unknown origin was not investigated as possible abuse.

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4. R31's incident report dated 3/1/13 at 3:45 p.m. documents R31 was noted to have swelling and bruising to the 4th finger on the left hand which was later found to be fractured. The incident report under the section titled "describe exactly what you observed or heard" documented "unable to make statement clear, stated she sleeps and had nightmares and that is how it happened, no witnesses." R31's Physician order sheet dated 8/1/13 documents R31 has Disorganized type Schizophrenia and Dementia. R31's history and physical documents R31 has delusions, hallucinations, poor judgement, poor memory, verbal aggression and flight of ideas. An abuse investigation was not completed. E1 (Administrator) signed the incident form on 3/4/13. The incident form was faxed to IDPH 3/4/13, 3 days after the injury of unknown origin occurred.

On 8/13/13 at 11:10 a.m. E1 (Administrator) stated E1 did not investigate this bruising and swelling as abuse because "you just have to know her (R31)."

5. A facility incident report dated 5/1/13 documents R32 punched R 34 in the head 3 times and then R32 pushed R34's wheelchair causing the wheelchair to propel. R32's history and physical documents R32 has a history of verbal and physical aggression and of making false accusations. R32 ' s care plan includes no documentation of review or new intervention after the 5-1-13 incident. An abuse investigation was not initiated. The incident form was not signed by E1 and IDPH was not notified until 5/2/13, 1 day later.

On 8/13/13 at 11:10 a.m. E1 confirmed that the

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incident was not reported or investigated as abuse and stated "well, they are boyfriend and girlfriend."

6. A facility incident report dated 6/18/13 at 1:00 p.m. documents R38 grabbed R37's walker, R37 then struck R38 in the eye. R38 then threw water on R37. E1 ' s signature on the incident report form is dated 6/19/13. IDPH was notified of the incident via fax on 6/19/13 at 10:10 a.m.

The care plan for R38 includes no documentation of review or new intervention after the 6-18-13 incident.

On 8/13/13 at 11:10 a.m. E1 confirmed that the incident was not reported or investigated as abuse.

On 08/14/13 at 1:00 PM an Immediate Jeopardy was identified to have begun on 12-03-12 when R18 was identified as having assualtive behaviors towards other residents. On 08/14/13 at 1:15PM E1/Administrator was notified of the Immediate Jeopardy.

The surveyor confirmed through record review and interview that the facility took the following actions to remove the Immediate Jeopardy:

1) Amendment of the facility Abuse Policy to reflect throughout the policy that the facility Administrator will be notified immediately if there is a suspected case of abuse. This same policy also includes notification of state agency (IDPH) as soon as possible.
2) Education of staff on policy changes and expectations of all staff members with regard to notifying Administrator and IDPH of suspected

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F 226	Continued From page 35 abuse. 3)R18 has been removed from the building and admitted for a psychiatric evaluation. A notice of immediate discharge has been given. 4) Facility form to include a mechanism of staff reporting for the person suspecting abuse to fill out and give to the approprate person in charge at the time of the suspected abuse. Education of staff on this form was completed. 5) Establishment of an Abuse Prevention Compliance Committee who will meet after every suspected allegation of abuse and is responsible for gathering all information, interview, investigation and reporting of their findings to the Administrator. Effective 08/14/13. 6) New form for notification of IDPH. One form will be an initial report form that will be used to do the inital notification to the deparment while the other form is for notification of the final results of the investigation.. Effective 08/14/13. 7) Prescreening of all potential residents by the IDT (Interdisciplinary Team) prior to admission to determine the risk to abuse/be abused. 8) Immediate care planning of all residents with the potential to be abused. 9) Risk assessment for abuse is to be done on all current residents. An aggression and violence screening form will also be completed. Any deficits identified in these areas will be addressed on the residents care plan to maintain safety for all residents. Completion date 08/21/13.	F 226		
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	F 315		

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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 properly empty an indwelling urinary catheter bag for one of two residents reviewed for catheters (R16) in a sample of 17.

Findings include:

On 8-12-13 at 10:40 AM. E12 (Certified Nurse Aide) took R16 into the shower room to assist R16 with urinary catheter care which included emptying R16's urinary catheter bag. E12 washed R16's catheter tubing and perineal area then assisted R16 to stand near the shower drain. While R16 was standing, E12 opened the closure device to R16's urinary catheter bag allowing urine to drain to the floor around R16's bare feet. E12 then rinsed R16's perineal area with the shower nozzle allowing water to drain down to R16's feet rinsing them as well.

A facility policy on emptying urine from a drainage bag page 98 (No date available) documents for staff to use a, "plastic, metal or glass measuring container..." when emptying urine from a catheter bag. The policy documents, "If spillage of body fluids occur while administering the procedure, clean it up as soon as you can. (Note: small spills of body fluids can be safely cleaned up with

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F 315	Continued From page 37 paper towels and bleach.)" The policy also documents to , "...pour urine down the commode..." On 8-13-13 at 12:00p.m. E2 (Director of Nurses) verified that a resident's urinary catheter bag should not be emptied by allowing urine to drain from the bag to the floor around a resident's feet by stating, "Absolutely not!"	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to correctly verify the	F 322		

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F 322	Continued From page 38 placement and patency of a gastric tube prior to instilling fluid into the gastric tube for one of one residents (R15) reviewed for gastric tubes in a sample of 17. Findings include: A facility gastric tube protocol dated as revised 10/2007 documents for staff to verify placement and patency of the gastric tube by first, "...inject air into tubing...before intermittent feedings, medications, or flushing." On 8-12-13 at 11:00a.m. E5 (Licensed Practical Nurse) was preparing to instill a bolus of liquid (flushing)into R15's gastric tube. E5 applied a stethoscope to R15's abdomen then listened to R15's abdomen while instilling a syringe of water through the gastric tube. E5 then reapplied the stethoscope to R15's abdomen a second time and listened again while instilling a bolus of air through R15's gastric tube. E5 stated at that time that, " The way to check placement is to put in a little water, listen, then put in a little air, then listen."	F 322		
F 323 SS=G	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	F 323		

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by:
Based on observation, interview, and record review the facility failed to re-assess and implement individualized interventions for two of seven residents (R13 and R18) requiring increased supervision in the sample of 17 and one resident requiring increased supervision on the supplemental sample (R23).
This failure resulted in R18 being physically aggressive to staff and multiple residents including R17, who sustained a hematoma to the left chest and soft tissue swelling and bruising all over the body. The failure also resulted in R23 pushing R13 down and causing a pelvic fracture to R13.

Findings include:

1. A physician's order sheet (POS) dated, 8/2013, documents that R18 has diagnoses which include: Asperger's Syndrome, Obsessive Compulsive Disorder, Schizophrenia, Depression, Cluster C Traits. The POS documents that R18 has medications which include: Ativan 1 mg (Milligram) intramuscularly injection to be given every six hours as needed for 72 hours dated 8-08-13, Risperidone 2 mg three times daily, Lamictal 100 mg two times daily, Klonopin 1 mg three times daily. The POS also included an order for Ativan 1 mg intramuscularly injection given as a now dose on dated 8-02-13.
A Minimum Data Set (MDS) Assessment, dated 6-20-13, documents that R18 is moderately cognitively impaired, independently mobile, and displayed verbal behavioral symptoms directed toward others four to six days per week. The MDS documents that R18's behaviors, "Put others at significant risk for physical

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injury...Significantly disrupt care or living environment."
Nurse's Notes, dated 9/2012 through 12/2012, document that the first incident of R18 becoming combative was 9-07-12. The Nurse's Notes document the first incident of R18, "trying to hit another resident," was 12-03-12. The remaining Nurse's Notes, dated 12/2012 to 8/2013, document multiple, frequent incidents of R18 hitting or attempting to hit facility staff and residents, entering resident rooms uninvited, throwing dishes, kicking, or attempting to hit others with R18's walker.
A facility incident report, dated 12-19-12, documents that R18 was, "hitting and kicking staff with closed hand and other residents." The incident report also indicates that R18 was witnessed kicking E27 (Registered Nurse). The incident report documents that R18 was removed, "from hostile environment to prevent harm from self and others."
A facility incident report, dated 3-18-13 documents that, "Another resident (R18) hit R39 on the back of the neck for no reason... R39 was sitting in reclining wheel chair in dining room." The incident report documents that, "Staff (counseled) on keeping R18 away from the other resident (R39) as much as possible and monitor closely when they are in the same room." A second incident report for the same incident, dated 3-19-13, documents that R18 also was attempting to, "kick another staff and resident." The incident report documented E 28 (Certified Nurse Aide), "Was in the dining area and resident hit at me twice and tried to kick me..."
A facility incident report, dated 8-12-13, documents that R18, "Entered another resident's room (R21) and struck R21 on the left forearm for an unknown reason. When asked why R18 did it,

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R18 said, 'I had to,' Neither resident was injured."
The incident report indicates that the "recommended steps to prevent recurrence" included, "R18 had recent med increase. R18 is to be redirected when going down hall and kept from going into others rooms without permission. When R18 is having behaviors redirect to R18's room or the nearest quiet place. Resident on 30 minute checks."
A facility incident report dated 8-13-13 documents that, "E14 (Assistant Director of Nurses) observed R18 running into another resident (R28) unintentionally with R18's walker pushing R28 up against the wall...(R18) also approached E14 in the medication room and struck E14 on the left wrist with R18's hand."
A care plan dated 9-13-12 documents that R18, "...has a history of verbal and physical aggression...R18 does not like to be touched...hits staff, throws trays." R18's behavior care plan interventions include: "explain R18 cannot use physical aggression and the importance of not being verbally or physically aggressive to anyone." The care plan also includes the intervention of providing, "1 to 1" supervision for R18 "Daily and as needed."
On 8-13-13 at 11:30 AM. R18 was in the hallway in front of the nurse's station. R18 was yelling unintelligibly while pushing R28 against the wall with a walker. E14 (Assistant Director of Nurses) approached R18 and loudly stated to R18, Don't do that." and led R18 down the hall towards R18's room.
On 8-14-13 at 9:05 AM. R21 stated that on 8-12-13 R18 entered R21's room and hit R21 in the arm. R21 stated that R18 has hit R21 at least four to five times in the past. R21 stated, "(R18) just rams me with the walker hard enough that if I was using my cane I would have gone down."

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R21 stated that, "(R18) is far too dangerous." R21 stated that when R18 hit R21 on the arm facility staff removed R18 from R21's room while at the same time telling R18, "(R18) couldn't get any pudding or something." R21 stated, "I do everything to avoid (R18) but (R18) comes up behind me. (R18) lives right by me and (R18) will see me come out of my room then (R18) will come right out and come after me" R21 stated, "I'm 64 years old and I've never been bullied until now."

On 8-14-13 at 11:00 AM. E9 (Registered Nurse), E16, and E17 (Certified Nurse Aides) were at the nurses station. E9 stated that R18's behaviors had increased recently but that R18's behaviors were actually just getting back to normal now that R18's medical problems were improving. E17 stated that R18 had hit E2 (Director of Nurses)and E17 on 8-09-13 and had hit E17 also on 8-13-13. E17 stated, "(R18) got E2 last Friday and got me last Friday too. (R18) got me yesterday too." E17 stated, "Back about a month ago (R18) came up behind me and hit me on my back." E16 stated, "(R18)threw a walker at my back and on 8-09-13, (R18) came from behind and tried to hit me on my back." E16 stated, "And he tried to choke me." E16 stated that the incident had not been documented on an incident report because, "I knew that was just his behavior." E9 stated that some of R18's behaviors were because R18 wanted chocolate pudding stating, "I just walk R18 back to R18's room and give R18 what R18 wants."

On 8-14-13 at 2:55 PM. E14 (Assistant Director of Nurse's) stated that when R18 becomes agitated, threatens to hit or kick, or actually hits or kicks staff and residents, R18 is redirected to R18's room. E14 stated that R18, "gets better for awhile then gets aggressive. (R18) doesn't pick

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his people, it's just anyone who is near. (R18) will say, 'I need to hit you."
R17's Nurse's Notes dated 8/12/13 at 5:50 p.m. document "it was brought to my attention a softball size lump had appeared on R17's left upper chest. It was not there during 2:30 p.m. rounds." The Nurse's Note at 7:15 p.m. documents "now bruised and appeared larger." R17's note at 7:15 p.m. documents "now bruised and appeared larger. send to emergency for evaluation, possible fractured rib."

R17's Resident Transfer Form from the facility to the emergency room, dated 8/12/13 at 5:50 p.m., documents " injury of unknown origin, left upper chest, soft ball sized bump."

R17's Preliminary Field Medical Report, dated 8/12/13, documents "hematoma above left nipple, bruise." R17's Emergency Transport Patient Care Report documents "large hematoma above left nipple, contusions and bruising all over body." The form documents chest, upper left arm and upper left leg as "soft tissue swelling and bruising." This form also documents under the Narrative section "(R17) was found laying in bed in the facility. "large edematous lump above left nipple up to shoulder about the size of a baseball. Patient (R17) also has bruising to his left upper arm and all across his chest. There is also bruising noted on legs. RN (Registered Nurse) stated being unsure of what happened to the patient but whatever occurred must have happened between 2 PM and 5 p.m. that day (8/12/13)."

R17's Summary of Current Hospitalization Emergency Room Note, dated 8/12/13, documents R17 was admitted from the facility

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with left chest hematoma. It also documents, "The emergency room staff contacted elder abuse hotline due to multiple ecchymotic(bruising) areas to skin and concern for abuse." Under the section of this form titled Assessment it documents "left chest hematoma, uncertain etiology, multiple bruises on body, social services following regarding potential elder abuse." R17's hospital record documents "5 inch diameter hematoma on left anterior chest. Ecchymosis (bruising) in left axillary region. Ecchymosis on right anterior chest wall. Multiple small lesions over legs." On 8/13/13 at 9:22 AM, Z2 (Admitting Emergency Room Physician) confirmed that the above-referenced note accurately represents R17's condition on admission to the Emergency Room.

On 8/13/13 at 11:45 AM, R17 was unable to respond appropriately to questions and just repeated "yes." R17 had a softball size raised area on R17's left upper chest. R17 had dark purple bruising in the left axilla which extended down to the elbow. R17's entire left bicep area was bruised. R17 had scattered bruising all the way across the chest just below the nipple line. R17's left foot had purple bruising starting at the left great toe and extending up the length of the foot about 1 1/2-2 inches wide. R17 had a pea sized scabbed area on the left great toe and left knee.

On 8/13/13 at 12:45 p.m. E13 (Nurse) stated that on 8/12/13 at 2:30 p.m. R17 was fine but when E15/CNA (Certified Nursing Assistant) got R17 up for dinner is when a red flat areas were discovered on R17's left chest, "don't know what

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it was, no one heard any noise or commotion from R17 and R18's room." E13 stated E2 (Director of Nursing) instructed E13 to chart the red area as an injury of unknown origin. E13 stated after dinner E13 reexamined R17 and found the red area to be bruised. E13 stated being "at loss as to what happened to R17."

On 8/13/13 a signed statement by E15 CNA (Certified Nursing Assistant) documented on 8/12/13 at 5:30 p.m. E15 went to get R17 up for dinner and noticed a large bump on R17's left chest. E15 asked R17 what happened and R17 stated "(R18) been hitting me." Attempts to contact E15 were made without success.

On 8/14/13 at 11:00 a.m. E16/CNA stated the following: Last Friday (8/9/13), between 9:45 a.m. and 10:00 a.m., E13 (Nurse) asked for help because R18 was in his room fighting with R17. E16 saw R18 hit R17. E13 (Nurse) directed E16 to get R17 up and out of his room because R18 was hitting R17 in his chest. E16 started getting R17 up and E13 had to hold R18 back so the staff could get R17 up. E13 also saw R18 hit R17.

On 8/14/13 at 11:00 a.m. E9/LPN (Licensed Practical Nurse) stated the following: Last Friday (8/9/13) E13 (Nurse) had staff get R17 up and out of is room because R18 was hitting R17 in the chest. E9 saw R18 hit R17. E13 (Nurse) asked for help because R18 was fighting with R17 and E13 had to hold R18 so staff could get R17 up.

2. An accident/incident report dated 11-19-13 at 4:30 a.m., documents
R23's nurse's notes dated 12-21-12 at 2:45 a.m., document R23 hit R40 in the mouth because R40 took R23's radio and ate R23's food. The

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accident report does not include interventions to prevent a recurrence of R23's behaviors.

R23's POS dated 3-1-13, documents R23 had diagnoses of impulse control, and mood disorder.

R13's current Physician Order Sheet (POS) documents R13 has a diagnosis of Senile Dementia.

A facility report dated 3-26-13 at 9:43 a.m. and signed by E2 (Director of Nursing), documents on 3-25-13 at 5:45 p.m., R13 walked into R23's room. R23 became upset because R13 entered the room and R23 pushed R13 down to the floor. R13 was sent to the emergency room for complaints of right hip pain. The facility report documents R23 was ticketed for battery and given a notice to appear in court. R13's pelvis and right hip x-ray dated 3-25-13, documents R13 had two acute fractures of the pelvis.

R13's accident/incident report dated 3-25-13 does not include new interventions to keep R13 from wandering into other resident rooms.

R13's current care plan does not include interventions to address R13 wandering in and out of other resident rooms.

On 8-13-13 at 1:30 p.m., E17 (Certified Nursing Aide/CNA) stated R13 is confused and has always propelled self in a wheelchair up and down the hallway and into other resident rooms.

On 8-15-13 at 1:15 p.m., E26 (Social Rehabilitation Worker) stated no interventions have been implemented with the facility staff or on R13's care plan to address R13 wandering in

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and out of resident rooms. E26 states, "I was not even aware that R13 wanders in and out of resident rooms."

On 8-13-13 at 2:40 p.m., E1 (Administrator) stated R13 likes to frequently wander into other resident rooms.

R23's nurse's notes dated 1-8-13 at 8:00 a.m., document R23 was "yelling and telling people to get out of the room."

R23's nurse's notes dated 3-25-13 at 5:45 p.m., document R23 "got mad" because R13 came into R23's room, and R23 pushed the resident (R13) down. The 3-25-13 nurse's notes document R23 feels no remorse and R23 stated, "No one should come into my room." R23's accident/incident report dated 3-25-13 does not include new interventions to prevent a recurrence of R23's behaviors towards other residents.

On 8-14-13 at 9:15 a.m., E6 (CNA) stated R23 would curse and fight with staff and residents almost everyday. E6 stated the residents were scared of R23.

On 8-14-13 at 10:30 a.m., E9 (Licensed Practical Nurse/LPN) stated R23 was physically and verbally abuse to residents and staff. R23 stated if other residents entered R23's room, R23 would push the residents out of the room and throw things at them.

On 8-15-13 at 1:15 p.m., E26 (Social Rehabilitation Worker) stated R23's interventions to deal with behaviors were basically talking with R23 and telling R23 "you can't hurt people." E26 stated "I was unaware of (R23) ever hitting other

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F 323	Continued From page 48 residents." E26 stated no new interventions were implemented on R23's care plan regarding R23's verbal and physical behaviors towards R13 on 3-25-13 or towards R40 on 12-21-12. On 8-13-13 at 2:40 p.m., E1 (Administrator) stated R23 was known to not like other residents in R23's room or space.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		

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(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 329	Continued From page 49 by: Based on record review and interview the facility failed to provide a medical indication for use of two antipsychotic medications for one of six residents (R16) reviewed for antipsychotic medication use in a sample of 17. Findings include: A physicians order sheet (POS) dated as 7-30-13 documents that R16 has diagnoses which include: Cerebral Palsy, Mild Mental Retardation, Anxiety, and Depression. The POS also documents that R16 has medications which include: Risperidone 0.5 mg (Milligrams) two times daily and Haldol 1 mg every eight hours for agitation as needed. On 8-13-13 at 12:00p.m. E2 (Director of Nurses) stated that E2 was responsible for monitoring residents who use psychotropic medications. E2 stated that all facility residents taking antipsychotic medications, "Should have a diagnosis for antipsychotic medications." E2 pointed out that R16 had a diagnosis of Anxiety as a justification for taking the antipsychotic medications Risperidone and Haldol. The Drug Information Handbook for Nursing 15th Edition documents that the antipsychotic medication Risperidone is used in the treatment of Schizophrenia, Acute Mania, Bipolar Disorder, or treatment of irritability/aggression associated with Autistic Disorder. The drug handbook documents that the antipsychotic medication Haldol is used in the treatment of Schizophrenia and Tourette's Disorder.	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 50 STORE/PREPARE/SERVE - SANITARY 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 operationalize a sanitation and food handling policy by not requiring dietary staff to wear hair and facial hair coverings while working in food preparation areas, not requiring dietary staff to wear gloves while handling opened food, failing to keep unused food securely covered while in the refrigerator, and by failing to properly sanitizing work surfaces. This failure has the potential to effect all 82 residents in the facility. Findings include: On 8-12-13 at 9:15 AM.. E18 (Dietary Manager), E20 (Dietary Aide), and E21 (Dietary Aide) were in the kitchen. E18's head covering only covered the front of E18's hair leaving the back completely exposed. The front of E20's hair was left uncovered, and E21 wore no restraint to cover E21's beard, mustache, and hair. E18 opened the refrigerator near the entrance to the kitchen where a tray of food was resting on a shelf with several glasses of beverages that were	F 371		

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uncovered. E18 then tested a bucket of bleach water used for sanitizing food contact surfaces in the kitchen. When E18 placed the test paper in the sanitizing solution to check the bleach content, the test paper did not indicate the presence of bleach in the water used to clean food contact surfaces.

On 8-12-13 at 11:30 AM. E18 (Dietary Manager), E20 (Dietary Aide), and E21 were in the kitchen getting ready for the noon meal. E18's head covering still covered only the front of E18's hair leaving the back completely uncovered. E20's head covering still did not cover the front of E20's hair. E21 still wore no restraint to cover R21's beard, mustache, and hair.

On 8-12-13 at 12:05 PM. E18 (Dietary Manager), E21(Dietary Aide), and E24 (Dietary Aide) were in the kitchen preparing for the noon meal. E21 was preparing resident's food plates by picking up hotdog buns with bare hands and putting the buns on the plates. E24 was not wearing a hair restraint. E18 stated that E21 did not need to wear gloves to handle food as long as R21 did not leave the food plating area.

A facility policy on sanitation page 93 (No date provided) documents that, "Hairnets or hair coverings over all of hair are to be worn at all times." The policy documents that staff should, "...not handle food with bare hands...use the proper utensil or wear disposable gloves...make sure surfaces are sanitized after each use and when changing food items...All unused food must be securely covered."

A facility census and condition report dated 8-12-13 and signed by E1 (Administrator)

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F 371	Continued From page 52 documents that at the time of the survey 82 residents resided in the facility.	F 371		
F 441 SS=E	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 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	F 441		

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infection.

This REQUIREMENT is not met as evidenced by:
A) Based on observation, record review and interview, the facility failed to ensure staff wore gloves and performed handwashing after administering insulin injections and failed to disinfect blood glucose monitors after resident use, for one of four residents (R8) receiving insulin injections, in a sample of 17, and for two residents (R26, R27) receiving insulin injections in the supplemental sample. The facility also failed to ensure their policy regarding cleaning of blood glucose monitors was updated to reflect current standards of practice regarding infection control. Based on observation, interview, and record review, the facility also failed to follow isolation precautions for a resident with Methicillin Resistant Staphylococcus Aureus (MRSA), as required by facility policy. This failure had the potential to affect two of six residents (R11, R19) reviewed for infections in the sample of 17..

Findings include:

A. On 8/12/13 at 11:30 a.m., E8 (Registered Nurse) administered R8's Humalog (Insulin) by subcutaneous injection. E8 did not wear gloves and did not perform handwashing after administering the injection. E8 then administered oral medications to R29. E8 returned to the medication cart and gathered supplies needed to verify blood glucose levels. E8 checked R26's blood glucose level without wearing gloves and did not perform handwashing prior to leaving the room. E8 returned the blood glucose monitor to

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the medication cart, without disinfecting the monitor. E8 then used the same blood glucose monitor and checked R27's blood glucose level without wearing gloves. E8 returned to the medication cart, touching multiple items. E8 then administered R27's Humalog by subcutaneous injection, without wearing gloves or handwashing. E8 returned to the medication cart and indicated she was finished checking the blood glucose levels of the residents on the A Hall. E8 placed the blood glucose monitor in the drawer of the medication cart without disinfecting it.

On 8/12/13 at 12:05 p.m., E8 stated staff are to clean the blood glucose monitors with Gluco-Chlor wipes "once per shift."

On 8/12/13 at 2:20 p.m., E2 (Director of Nursing) stated staff are to disinfect blood glucose monitors after each resident use, not once per shift. E2 stated all staff should be wearing gloves when administering injections or obtaining blood glucose levels and should always wash their hands after direct resident contact.

The facility policy, titled "Handwashing", indicates staff should wash their hands "after contact with blood, oral secretions, mucous membranes, broken skin" and "after handling items or work surfaces potentially contaminated with a resident's blood, excretions, or secretions."

The facility policy, titled "Blood Glucose: Calibration and Control Solution Test", is dated 3/2000. The policy indicates staff are to "clean the monitor each day it is used", not after each resident use. Additionally, the "Blood Glucose: Calibration and Control Solution Test" policy did not specify what should be used to effectively

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disinfect the blood glucose monitor.

B. On 8/14/13 at 10:10 a.m., R19 and R11 were both asleep in separate beds their room. A sign on the door of the room stated "contact precautions: wear gown and gloves."

R19's Physician Order dated 8/6/13, documents to collect bilateral nares culture then start Bactroban daily for five days then re-culture bilateral nares in one week for diagnosis of MRSA.

Lab reports dated 8/9/13, document R19 tested positive for MRSA of bilateral nares.

Methicillin Resistant Staphylococcus Aureus Policy and Procedure dated 4/00, documents residents infected with MRSA can only be placed in a room with other MRSA infected residents.

On 8/14/13 at 1:10 p.m., R19 stated R19 has a diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA) of the nares and is being treated with "an ointment" daily. R19 confirmed that R19 has a roommate.

On 8/15/13 at 9:30 a.m., E2 (Director of Nursing) referenced the MRSA policy and procedure regarding cohorting of residents with infections and was unable to provide information regarding R19 having a roommate (R11), who does not have MRSA. E2 stated "I'll have to get back to you on that."

On 8/15/13 at 11:15 a.m., E2 (Director of Nursing) stated R11 was moved to a different room and R19 was now in a private room due to the diagnosis of MRSA.

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F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all emergency exit doors functioned properly. This failure has the potential to affect all 82 residents living in the facility. Findings include: On 8/12/13 at 2:15 p.m., the exit door in the dining room (near the A Wing) failed to open when the magnet on the door would not disengage after the 15 second security delay. On 8/12/13 at 2:15 p.m., E25 (Maintenance Supervisor) indicated the door should open, as it is an emergency exit. E25 stated the door had functioned properly earlier in the day and was uncertain as to why it would not open. According to The Resident Census and Condition Report, 82 residents were in the facility on 8/12/13.	F 456		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to have a quality assessment assurance system in place to identify causes, patterns, and trends regarding repeated abusive and/or harmful resident behaviors, and failed to have a physician in attendance for quarterly quality assurance meetings. These failures have the potential to effect all 82 residents in the facility.

Findings include:

A review of facility incident reports dated 8/2012 to 8/2013 document that R18 had been involved in four incidences of physically abusive behavior with other residents within the facility. Nurses notes dated 9/2012 to 8/2013 document that R18

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had a history of hitting staff and residents, entering residents rooms uninvited, and throwing food trays.

On 8-13-13 at 2:55 PM. E14 (Assistant Director of Nurses) stated that R18 walks independently using a walker throughout the facility. E14 stated that R18 had a history of "behaviors and non compliance" E14 stated that R18 doesn't pick who he directs his behaviors towards, "Just whoever is near. He'll say, 'I need to hit you,' repeatedly. E14 stated regarding R18, "It's just behaviors." E14 stated that R18 has times when R18, "gets better then gets aggressive." E14 stated that when R18 has behaviors staff try to redirect R18 to R18's room or that staff offer "chocolate pudding" as a means to prevent R18 from having aggressive behaviors.

On 8-14-13 at 12:45p.m. E2 (Director of Nurses) stated that since accepting the position as Director of Nurses in 11/2012 E2 has attended all of the facility's Quality Assurance (QA) meetings. E2 stated that no physician had attended any of the QA meetings. E2 also stated, "I can't recall resident behaviors being discussed during the QA meetings, but I can't be sure." E2 stated that, "I can't recall that R18 was ever brought up in QA meetings."

On 8-14-13 at 12:55 PM. E22 (Activities Director) stated that E22 attends all Quality Assurance (QA) meetings. E22 stated that there had not been a physician who attended any of the QA meetings. E22 stated that there had not been a discussion of what the facility should do about R18's behaviors. E22 stated that there had been no discussion of behaviors at any of the QA meetings.

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F 520	Continued From page 59 On 8-14-13 at 1:05 PM. E23 (Restorative Nurse) stated that E23 attends all Quality Assurance (QA) meetings. E23 stated that "occasionally" a physician attends the QA meetings but was unable to state when a physician had last attended. Facility Quality Assurance (QA) attendance logs dated 1-10-13 to 8-09-13 do not include documentation that a physician attended any meetings. On 8-15-13 at 2:15 PM. E1 (Administrator) confirmed that there had been no physician in attendance at any of the facility's Quality Assurance meetings. A facility Census and Condition Report dated 8-12-13 and signed by E1 (Administrator) documents that at the time of the survey 82 residents resided in the facility.	F 520		