CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		145674	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	140014		ST 50	REET ADDRESS, CITY, STATE, ZIP CODE 9 SOUTH BUCK ROAD, PO BOX 149 E ROY, IL 61752	03/	06/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	IL#68021 - no deficie	nvestigation 1460573/ ncy 157, F223, F224, F226,					
F 157 SS=D	A partial extended su 483.10(b)(11) NOTIF (INJURY/DECLINE/R	Y OF CHANGES	F	157			
	consult with the resid known, notify the resid or an interested famil accident involving the injury and has the pol intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treatr consequences, or to treatment); or a decis the resident from the §483.12(a).	nent due to adverse commence a new form of ion to transfer or discharge facility as specified in					
	and, if known, the res or interested family m change in room or roo specified in §483.15( resident rights under regulations as specifi this section.	Federal or State law or ed in paragraph (b)(1) of					
LABORATORY	-	rd and periodically update			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/10/2014

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/10/2014 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		145674	B. WING			_		C 06/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LEROY M					509 SOUTH BUCK ROAD,	PO BOX 149		
	ANON				LE ROY, IL 61752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page the address and phor legal representative of This REQUIREMENT by: Based on interview a failed to promptly noti Power of Attorney afte condition for two of tw reviewed for change i five. Findings include: An abuse investigatio that on 2-23-14 at 1:0 on top of roommate (I and nose." On 2-26-14 at 10:50a Aide) stated that on 2 E15 and E18 (Certifie nurse's station when down the hall. E15 stated taken off of R5's mour responsive. E15 stated started patting R5's fa lifting R5's arms and I E15 stated, "It was a was a very serious sit	e 1 ne number of the resident's r interested family member. is not met as evidenced nd record review the facility fy a resident's physician and er a change in resident		157	!			
	history of behaviors b harmed anyone befor On 2-26-14 at 9:55a.r							

Facility ID: IL6012157

If continuation sheet Page 2 of 24

	-	D HUMAN SERVICES				FORM	: 03/10/2014 APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED
		145674	B. WING			03/	C 06/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, P E ROY, IL 61752	O BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	E18 entered R4's roo Aide) had already pull mouth and nose. E18 respond for 20-30 sec touched R5's face, an took 20-30 seconds to that R4 had a history included walking into without permission, "c and agitation. E18 st physically harmed any aware. On 2-26-14 at 9:18a.r Nurse) stated that on R4 was found with ha and nose, R4 was ren taken to the nurse's s E12 could telephone I instructions. E12 ver physicians and familie incident because E1 to in the morning." E12 meant calling the doc stated that a fax repor physician's office after that no one would hav office opened. Nurse's notes dated 2 documented, "(R5) sk seconds after incident On 2-26-14 at 9:18a.r Nurse) stated that after and R5, a fax regardin	-23-14 at 1:00a.m. when m, E15 (Certified Nurse led R4's hands from R5's 3 stated that R5 did not conds. E18 stated, "I ad rubbed R5's chest It b arouse R5." E18 stated of intrusive behaviors which other residents rooms constantly drug seeking," ated that R4 had never y one as far as E18 was n. E12 (Licensed Practical 2-23-14 at 1:00a.m. after nds covering R5's mouth noved from the room and tation for supervision so E1 (Administrator) for ified that R4 and R5's es were not called after the told E12, "I'll take care of it stated, "I assumed that tor and the family too." E12 rt was sent to R4 and R5's r the incident occurred, but ve seen that fax until the 2-23-14 at 1:21a.m. ow to respond for 30 t. (E1) notified of incident." m. E12 (Licensed Practical er the incident between R4 ng the incident was sent to and R5's Physician) on	F 157				

Facility ID: IL6012157

If continuation sheet Page 3 of 24

	-					FORM	03/10/2014 APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	LETED
		145674	B. WING			03/0	C 06/2014
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
			5	09 SOUTH BUCK ROAD, PO BOX	149		
LEROY M	ANOR		L	E ROY, IL 61752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 157	Continued From page	3	F 157				
	that R5's physician wa incident or R5's unres incident until 10:01a.n	dated 2-23-14 document as not verbally notified of the sponsiveness following the n., and R5's POA (Power of ified until 12:13p.m., over 11					
	R4's physician's office behavior by fax on 2-2 and that R4's POA (P	23-14, which was a Sunday, ower of Attorney) was b:50a.m., over eight hours					
F 223 SS=L	12/2002 documents, " notify the resident, an representative, and hi	is or her attending physician dent's condition and/or 1)(i) FREE FROM	F 223				
		right to be free from verbal, mental abuse, corporal luntary seclusion.					
	The facility must not u or physical abuse, cor involuntary seclusion.						
	by: Based on observation review the facility faile	is not met as evidenced n, interview, and record ed to follow their policy and of other residents after					

Facility ID: IL6012157

If continuation sheet Page 4 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/10/2014 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COMF	E SURVEY PLETED
		145674	B. WING				C / <b>06/2014</b>
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				5	509 SOUTH BUCK ROAD, PO BOX 149		
	ANOR			L	LE ROY, IL 61752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	notify law enforcement resident (R5) by anoth attempted to suffocate impaired resident, R5 one observation as sp which placed other re- failures have the poter residents in the facility an Immediate Jeopart While the Immediate Jeopart While the Immediate Jeopart While the Immediate Jeopart While the Immediate Jeopart Severity level two as management and star policy. Findings include: On 2-26-14, an Imme identified to have beg when R4 was witness R5, R4's roommate. A facility Abuse Prohil revised 10/2012 docu attention will be given increased the residen or others or being the behaviors would inclu aggressive behaviors entering other resider communication disord heavy nursing care at on staff." The policy a administration shall in enforcement authoriti physical abuse." The	buse occurred, and failed to ht of an assault of one her resident (R4). R4 e R5, a severely cognitively was not placed on one to becified in the facility policy, sidents at risk. These ential to affect all 80 y. These failures resulted in dy. Jeopardy was removed on emains out of compliance at is the facility is still educating ff on the Abuse Prohibition diate Jeopardy was un on 2-23-14 at 1:00a.m. sed attempting to suffocate bition Policy dated as iments that, "Special to identifying behavior that it's potential for abusing self victim of abuse. These ide residents with	F	223	3		

Facility ID: IL6012157

If continuation sheet Page 5 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/10/2014 / APPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION			SURVEY LETED
		145674	B. WING					。 06/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
LEROY M	ANOR				509 SOUTH BUCK ROAD, PO LE ROY, IL 61752	O BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 223	protect all residents in the alleged perpetrato that, "the suspected supervised 1:1 or kep all other residents unt indicates that, "The sh resident's attending p A facility abuse invest documents that at 1:0 "CNA(Certified Nurs top of R5 with (R4's) h and nose." The invest was moved to a priva transferred to the hos diagnosed with Homic On 2-26-14 at 9:18a.r Nurse) stated that on with hands covering F was removed from the nurse's station for sup telephone E1 (Admini R4 and R5's physicial called after the incide take care of it in the m assumed that meant of family too." E12 state conversation with E1, facility did not have er observation and that I said to monitor (R4) c during the conversatio already talked to R4's more incident and R4 verified that following	ke all steps necessary to a the facility from abuse until or can be evaluated," and a resident shall be at physically separated from til further orders." The policy hift nurse shall call the hysician." tigation dated 2-24-14 10a.m. on 2-23-14, se Aide) found R4 lying on hands over (R5's) mouth stigation documents that R4 te room and eventually pital where R4 was cidal Ideation. m. E12 (Licensed Practical 2-23-14 after R4 was found R5's mouth and nose, R4 te room and taken to the bervision so E12 could istrator). E12 verified that ns and families were not nt because E1 told E12, "I'll norning." E12 stated, "I calling the doctor and the	F	223				

Facility ID: IL6012157

If continuation sheet Page 6 of 24

		ID HUMAN SERVICES					FORM	): 03/10/2014 // APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				(X3) DATE	D. 0938-0391 SURVEY LETED
		145674	B. WING			_		C 06/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEROY M	ANOR				09 SOUTH BUCK ROAD, F E ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	≥6	F	223				
		.m. E15 (Certified Nurse						
	,	2-23-14 at around 1:00a.m. ed Nurse Aide) were near the						
		"yelling" could be heard from tated that E18 stopped for						
	gloves while E15 wen	nt into R4's room and found						
	· ·	hands covering R5's mouth d that once R4 was pulled off						
		Practical Nurse) entered the						
	room and asked R4 if covering another resid	dent's nose and mouth,						
	keeping them from br serious harm. E15 st							
	understanding what F	R4 had done. E15 stated						
		were taken off of R5's was not responsive. E15						
	stated that both E15 a	and E18 started patting R5's						
		est, and lifting R5's arms respond. E15 stated, "It						
	÷	er forget. It was a very bok me about an hour to						
	calm down."							
		m. E18 (Certified Nurse						
		n E18 entered R4's room ., E15 (Certified Nurse Aide)						
	had already pulled R4	4's hands from R5's mouth						
		d that R5 did not respond for stated, "I touched R5's face,						
		st It took 20-30 seconds to ted that R4 had a history of						
	intrusive behaviors wl	hich included walking into						
	other residents rooms "constantly drug seek	s without permission, king," and agitation. E18						
	stated, "We spent a lo	ot of time baby sitting R4						
	because of R4's beha	IVIOIS.						
	On 2-26-14 at 9:00a.r	m. E17 (Licensed Practical						

Facility ID: IL6012157

If continuation sheet Page 7 of 24

CENTER STATEMENT ( AND PLAN OF	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145674	· /	S	E CONSTRUCTION	TE, ZIP CODE	FORM OMB NC (X3) DATE COMP	D: 03/10/2014 MAPPROVED D. 0938-0391 SURVEY LETED C 06/2014
LEROY M	ANOR				509 SOUTH BUCK ROAD, PO LE ROY, IL 61752	0 BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 223	Nurse) stated that 2-2 between R4 and R5, I care at the end of the R4 arrived to the new E17 verified, "No one limited with staffing ar sit with R4. So betwee Nurse Aides) and I, w minutes." On 2-26-14 at 1:35a.r Aide) stated that on 2 was transferred to the working. E13 stated t enough staff available (Certified Nurse Aide) every 15 minutes. E1 to block the bathroom R4 so R4 could not ga room. On 2-26-14 at 2:35p.r Nurse) verified that E E1(Administrator) the before 10:00a.m. bec the facility to decide w stated that while talkin memory of being calle Practical Nurse) after between R4 and R5. conversation with E1, R4 and R5's physician also stated R4 and R4 informed once E1 arri stated that R4's physi transfer R4 to the hos stated the police were to resident assault un	23-14 after the incident R4 was transferred to E17's hall. E17 stated that when room, R4 was "agitated." sat with R4. We were very nd I couldn't pull someone to een the two CNAs (Certified re checked on R4 every 15 m. E13 (Certified Nurse -23-14 after the incident, R4 e 100 hall where E13 was that because there was not e to watch R4, E13 and E14 ) took turns monitoring R4 13 stated that they decided n from the adjacent room to ain access to that resident's m. E10 (Licensed Practical 10 telephoned morning of 2-23-14 just ause E1 had not arrived at what to do about R4. E10 ng to E1, E1 denied any ed by E12 (Licensed the incident occurred E10 stated during the . E10 was instructed to notify n of the incident, but that E1	F	223				

Facility ID: IL6012157

If continuation sheet Page 8 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/10/2014 MAPPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		145674	B. WING				C 8/06/2014
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LEROY M	ANOR				509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	only notified at that tin the emergency medic R4 to the hospital for On 2-26-14 at 2:45p.r head and shrugged si the facilty abuse proh that E1could not state outlined in the facility' actions should be tak abuse situation, statin policy says). I haven' asked about what situ enforcement notificati Physical harm?" E1 y had discussions with Attorney) about transt facility. E1 stated, "I'r son about how to mal have involved going to On 2-26-14 at 1:25p.r Director) stated that F changes since arriving stated that R4 didn't li noise, left lights on, of that it was E16 who d and R5 in the same ro E10 stated that becau watch TV, "I didn't thin R4 in a room with R5" On 2-26-14 at 2:20p.r verified that R4 should supervision following stated that prior to R4 1-08-14, R4 had "psy	noted that the police were ne to protect the safety of cal technicians transporting a psychiatric evaluation. In. E1 (Administrator) shook houlders when asked about ibition policy. E1 verified e what procedures were s abuse policy, or what en following a witnessed ng, "I don't know (what the t read it for a while." When lations require law on E1 replied, "I don't know. verified that the facility had R4's POA (Power of ferring R4 to a different n sure we talked to (R4's) ke R4 happy, and that might o another facility." In. E16 (Social Services R4 had had several room g at the facility 1-08-14. E16 ike roommates who made r had visitors. E16 stated etermined that placing R4 pom would, "be a good fit." use R5 was quiet and didn't nk it would be a risk to put ' n. Z1 (R4's Physician) d have been placed in 1:1 trying to suffocate R5. Z1	F	223			

Facility ID: IL6012157

If continuation sheet Page 9 of 24

		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/10/2014 // APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145674	B. WING			_		C 06/2014
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEROY M	ANOR				509 SOUTH BUCK ROAD, F LE ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	<ul> <li>could have been a data</li> <li>A Minimum Data Set A</li> <li>1-07-14 documents the impaired requiring total more staff for transfered MDS also documented</li> <li>E1 (Administrator) and Administrator) were in Jeopardy on 2-26-14</li> <li>A Facility Data Sheet by E1 (Administrator) of the survey 80 resided</li> <li>The surveyor confirmed record review that the actions to remove the actions to remove the survey and E2 (Director of Neurose).</li> <li>Facility's Abuse Provide the survey and the survey at the survey and the survey at the survey at</li></ul>	<ul> <li>Z1 stated, "I suppose (R4) nger to other residents"</li> <li>Assessment (MDS) dated hat R5 is severely cognitively al dependence of two or s and bed mobility. The d that R5 did not ambulate.</li> <li>d E4 (Corporate otified of the Immediate at 3:30p.m.</li> <li>dated 2-25-14 and signed documents that at the time ents resided in the facility.</li> <li>ed through interview and facility took the following Immediate Jeopardy:</li> <li>ohibition policy was ced to E1 (Administrator) ursing) by E3 (Corporate otherwise) by E</li></ul>	F	223				
	-	shall be responsible for						

Facility ID: IL6012157

If continuation sheet Page 10 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/10/2014 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145674	B. WING				C 1 <b>06/2014</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
LEROY M	ANOR				99 SOUTH BUCK ROAD, PO BOX 149 E ROY, IL 61752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	responsible for overse the Plan of Abatemen 5. A Quality Assuranc implemented under th (Administrator) or Des	eeing the implementation of ht. ce Program will be ne supervision of E1	F 2	223			
F 224 SS=L	compliance. 483.13(c) PROHIBIT MISTREATMENT/NE The facility must deve policies and procedur	GLECT/MISAPPROPRIATN elop and implement written res that prohibit t, and abuse of residents	F 2	224			
	by: Based on observation review the facility neg and enact their policy abuse. This resulted one resident (R4) after the roommate (R5). Tho notify law enforcement resident to resident as the potential to affect facility. This resulted While the Immediate 2-26-14, the facility re a severity level two as	T is not met as evidenced on, interview, and record glected to have knowledge of o on resident to resident d in inadequate monitoring of er R4 attempted to suffocate The facility neglected to nt immediately after the ssault. These failures have all 80 residents in the in an Immediate Jeopardy. Jeopardy was removed on emains out of compliance at s the facility is still educating iff on the Abuse Prohibition					

If continuation sheet Page 11 of 24

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С 145674 B. WING 03/06/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 509 SOUTH BUCK ROAD, PO BOX 149 LEROY MANOR LE ROY, IL 61752 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 224 Continued From page 11 F 224 Findings include: On 2-26-14, an Immediate Jeopardy was identified to have begun on 2-23-14 at 1:00a.m. when R4 was witnessed suffocating R5, R4's roommate. A facility Abuse Prohibition Policy dated as revised 10/2012 documents that, "Special attention will be given to identifying behavior that increased the resident's potential for abusing self or others or being the victim of abuse. These behaviors would include residents with aggressive behaviors,...behaviors such as; entering other residents rooms...residents with communication disorders, and those who require heavy nursing care and/ or are totally dependant on staff." The policy also documents that, "The administration shall immediately contact local law enforcement authorities," for resident to resident physical abuse." The policy documents that following an incident of alleged abuse, "...the Administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated," and that, "...the suspected resident shall be supervised 1:1 or kept physically separated from all other residents until further orders." The policy indicates that, "The shift nurse shall call the resident's attending physician." A facility abuse investigation dated 2-24-14 documents that at 1:00a.m. on 2-23-14, "...CNA(Certified Nurse Aide) found R4 lying on top of R5 with (R4's) hands over (R5's) mouth and nose." The investigation documents that R4 was moved to a private room and eventually transferred to the hospital where R4 was diagnosed with Homicidal Ideation.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IL6012157

If continuation sheet Page 12 of 24

PRINTED: 03/10/2014

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/10/2014 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145674	B. WING		_		C 06/2014
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
LEROY M	ANOR			09 SOUTH BUCK ROAD, I E ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	BPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	2 12	F 224				
	Aide) stated that durin of 2-23-14 around 1:0	.m. E15 (Certified Nurse ng the early morning hours 0a.m. R4 was found on top R5's mouth and nose e R5.					
	Nurse) stated that wh notified of the assault instructed to move R4 "monitor closely." E1: wanted R4 and R5's F and physicians to be facility later that morn the conversation with	POAs (Power of Attorney) notified once E1 came to the ing. E12 stated that during E1, E1 also stated, "I son about R4 and said one					
	Aide) stated that R4 h behaviors which inclu	n. E18 (Certified Nurse ad a history of intrusive ded walking into other out permission, "constantly pitation.					
	Aide) stated that in or	s room adjacent to R4's, d Nurse Aide) used a					
	Director) stated that F	n. E16 (Social Services A was placed in the same was quiet, didn't watch TV, here was any risk.					
		n. E10 (Licensed Practical and R5's physician was					

If continuation sheet Page 13 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 03/10/2014 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145674	B. WING		_	( 03/0	) 06/2014
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, E ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	occurred, and that law notified to provide saft technicians while tran On 2-26-14 at 11:35a stated that E2 takes of Abuse Coordinator while stated that after arriv around 9-9:30a.m E2 being supervised by si was not being supervited that law enforcement emergency medical te R4 to the hospital. On 2-26-14 at 2:45p.r head and shrugged si the facility abuse profit that E1 could not reca outlined in the facility' actions should be tak abuse situation, statin policy says). I haven' asked about what situ enforcement notificati Physical harm?" E1 v discussions with R4's about transferring R4 stated, "I'm sure we ta how to make R4 happ involved going to ano On 2-26-14 at 2:20p.r verified that R4 should supervision following that prior to R4 comin had "psych behaviors	over eight hours after it v enforcement was only fety to emergency medical isporting R4 to the hospital. .m. E2 (Director of Nurses) over responsibilities of the hen E1 is unavailable. E2 ing at the facility 2-23-14 at did check to see if R4 was staff. E2 verified that R4 ised one to one. E2 verified was only called to assist echnicians with transporting m. E1 (Administrator) shook houlders when asked about hibition policy. E1 verified all what procedures were s abuse policy or what en following a witnessed ng, "I don't know (what the 't read it for a while." When vations require law on E1 replied, "I don't know. verified that facility had had . POA (Power of Attorney) to a different facility. E1 alked to (R4's) son about by, and that might have	F 224				

Facility ID: IL6012157

If continuation sheet Page 14 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				INTED: 03/10/2014 FORM APPROVED IB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		) DATE SURVEY COMPLETED
		145674	B. WING			C 03/06/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE	
LEROY M	ANOR			09 SOUTH BUCK ROAD, PO BO E ROY, IL 61752	OX 149	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 224	<ul> <li>been a danger to other</li> <li>A Facility Data Sheet</li> <li>by E1 (Administrator)</li> <li>of the survey 80 reside</li> <li>E1 (Administrator) and</li> <li>Administrator) were in</li> <li>Jeopardy on 2-26-14</li> <li>The surveyor confirmer</li> <li>record review that the actions to remove the</li> <li>1. Facility's Abuse Priviewed and in-serviand E2 (Director of Network)</li> <li>2. Facility's Abuse Priviewed, and E2 (Director of Network)</li> <li>2. Facility's Abuse Priviewed, and in-serviand E2 (Director of Network)</li> <li>3. All interviewable resident of the appropriate of the approprise of the ap</li></ul>	<ul> <li>I suppose (R4) could have er residents"</li> <li>dated 2-25-14 and signed documents that at the time ents resided in the facility.</li> <li>d E4 (Corporate otified of the Immediate at 3:30p.m.</li> <li>ed through interview and facility took the following Immediate Jeopardy:</li> <li>ohibition policy was ced to E1 (Administrator) ursing) by E3 (Corporate</li> <li>ohibition policy and sin-serviced to all working ning staff will receive licy as they report to the</li> <li>esidents are being poriate room mates and nvironment.</li> <li>shall be responsible for ompliance and will be eeing the implementation of</li> </ul>	F 224			
	5. A Quality Assurance implemented under the (Administrator) or Des	e supervision of E1				

Facility ID: IL6012157

If continuation sheet Page 15 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/10/2014 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145674	B. WING				C 06/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, PC E ROY, IL 61752	) BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 224 F 226 SS=L	policies and procedur	IMPLMENT TC POLICIES lop and implement written es that prohibit , and abuse of residents	F 224 F 226				
	by: Based on interview a failed to follow their al resident (R4), alleged abuse, either in 1:1 s separate from all other the victim (R5) and th physician for a period incident occurred, and enforcement regardin abuse. The facility al policy by identifying F potentially leading to R5's severe cognitive dependence on staff for being abused prior roommates. These fa Immediate Jeopardy of potential to affect all 8 While the Immediate 2-26-14, the facility re a severity level two as	of nine hours after the d failed to contact law g the alleged physical so failed to follow it's abuse R4's intrusive behavior as abuse and failed to identify impairment and total as increasing the potential to making R4 and R5					

Facility ID: IL6012157

If continuation sheet Page 16 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 03/10/2014 APPROVED 2: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		145674	B. WING			( 03/	, 06/2014
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATI	E, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, PO E ROY, IL 61752	BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 226	when R4 was witness roommate. A facility Abuse Prohil revised 10/2012 docu attention will be given increased the residen or others or being the behaviors would inclu aggressive behaviors entering other resider communication disorc heavy nursing care ar on staff." The policy a administration shall in	diate Jeopardy was un on 2-23-14 at 1:00a.m. ed suffocating R5, R4's bition Policy dated as ments that, "Special to identifying behavior that t's potential for abusing self victim of abuse. These de residents with	F 226				
	physical abuse." The following an incident of Administrator shall tal protect all residents in the alleged perpetrator that, "the suspected supervised 1:1 or kep all other residents unt indicates that, "The sl resident's attending p A facility abuse invest documents that at 1:0 "CNA(Certified Nurs top of R5 with (R4's) I and nose." The invest	policy documents that of alleged abuse, "the ke all steps necessary to the facility from abuse until or can be evaluated," and I resident shall be t physically separated from il further orders." The policy hift nurse shall call the hysician." igation dated 2-24-14 (0a.m. on 2-23-14, se Aide) found R4 lying on hands over (R5's) mouth tigation documents that R4 te room and eventually pital where R4 was					

Facility ID: IL6012157

If continuation sheet Page 17 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES	-1			FORM	): 03/10/2014 / APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		145674	B. WING		_	03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, I E ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	: 17	F 226				
	Nurse) stated that on	n. E12 (Licensed Practical 2-23-14 after R4 was found R5's mouth and nose, R4					
	was removed from the nurse's station for sup	e room and taken to the pervision so E12 could					
	R4 and R5's physicial	istrator). E12 verified that ns and families were not nt because E1 told E12, "I'll					
	take care of it in the massumed that meant of	norning." E12 stated, "I calling the doctor and the					
		E1 was informed that the nough staff to keep R4 in 1:1					
	observation and that I said to monitor (R4) c	E1 stated, "I didn't say 1:1, I losely." E12 stated that					
	already talked to R4's more incident and R4	on with E1, E1 also stated, "I s son about R4 and said one would have to go." E12					
		the phone call with E1, R4 private room on another unit					
	Aide) stated that on 2	.m. E15 (Certified Nurse -23-14 at around 1:00a.m.					
	nurse's station when '	ed Nurse Aide) were near the "yelling" could be heard from ated that E18 stopped for					
	R4 on top of R5 with I	it into R4's room and found hands covering R5's mouth I that once R4 was pulled off					
	of R5, E12 (Licensed room and asked R4 if	Practical Nurse) entered the R4 was aware that					
	keeping them from brokerious harm. E15 st	-					
	understanding what R	R4 had done. E15 stated were taken off of R5's					
	mouth and nose, R5 v	was not responsive. E15					

Facility ID: IL6012157

If continuation sheet Page 18 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/10/2014 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		145674	B. WING		-	03/	C 06/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, P E ROY, IL 61752	O BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 226	face, rubbing R5's cha and legs to get R5 to was a sight I will never serious situationIt to calm down." On 2-26-14 at 9:55a.r Aide) stated that on 2 R4's room, E15 (Certi already pulled R4's ha nose. E18 stated tha 20-30 seconds. E18 and rubbed R5's ches arouse R5." E18 sta intrusive behaviors wh other residents rooms "constantly drug seek stated, "We spent a lo because of R4's beha On 2-26-14 at 9:00a.r Nurse) stated that after and R5, R4 was trans room at the end of the R4 arrived to the new E17 verified, "No one limited with staffing an sit with R4. So betwee Nurse Aides) and I, w minutes." On 2-26-14 at 2:35p.r Nurse) verified that E morning of 2-23-14 w the facility to decide v stated that while talkin memory of being called	and E18 started patting R5's est, and lifting R5's arms respond. E15 stated, "It er forget. It was a very ook me about an hour to n. E18 (Certified Nurse -23-14 when E18 entered ified Nurse Aide) had ands from R5's mouth and t R5 did not respond for stated, "I touched R5's face, st It took 20-30 seconds to ted that R4 had a history of hich included walking into a without permission, ing," and agitation. E18 ot of time baby sitting R4 wors." n. E17 (Licensed Practical er the incident between R4 iferred to E17's care in a e hall. E17 stated that when room, R4 was "agitated." sat with R4. We were very nd I couldn't pull someone to een the two CNAs (Certified e checked on R4 every 15 n. E10 (Licensed Practical	F 226				

Facility ID: IL6012157

If continuation sheet Page 19 of 24

CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	FOF OMB N	ED: 03/10/2014 RM APPROVED IO. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	. ,		. ,	MPLETED
		145674	B. WING		0	3/06/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
LEROY M	ANOR			509 SOUTH BUCK ROAD, PO BO LE ROY, IL 61752	)X 149	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 226	instructed to notify R4 incident but that E1 st would be called once E10 stated that once order from R4's physi hospital, an ambuland that the police were in transferring to the hos as a safety precaution technicians transporti psychiatric evaluation On 2-26-14 at 2:45p.r head and shrugged st the facility abuse prof that E1 was not sure outlined in the facility' actions to take followi situation, stating, "I do says). I haven't read about what situations notification E1 replied harm?" E1 verified th discussions with R4's about transferring R4 stated, "I'm sure we ta how to make R4 happ involved going to ano On 2-26-14 at 1:25p.r Director) stated that F changes since arriving stated that R4 didn't li noise, left lights on, of that it was E16 who d and R5 in the same re E10 stated that becau	versation with E1, E10 was and R5's physician of the sated R4 and R5's families E1 arrived at the facility. the facility received an cian to transfer R4 to the ce was called. E10 stated otified that R4 was spital, which is customary n for the emergency medical ng R4 to the hospital for a m. E1 (Administrator) shook houlders when asked about hibition policy. E1 verified what procedures were s abuse policy or what ng a witnessed abuse on't know (what the policy it for a while." When asked require law enforcement , "I don't know. Physical at facility had had POA (Power of Attorney) to a different facility. E1 alked to (R4's) son about by, and that might have	F 22	5		

Facility ID: IL6012157

If continuation sheet Page 20 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/10/2014 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145674	B. WING		_	03/0	; 06/2014
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEROY M	ANOR			09 SOUTH BUCK ROAD, I E ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	verified that R4 should supervision following that prior to R4 comin had "psych behaviors an acute care facility f adjusted. Z1 stated, " been a danger to othe A Minimum Data Set A 1-07-14 documents th impaired requiring tota more staff for transfer also documented that A Facility Data Sheet by E1 (Administrator) of the survey 80 resid E1 (Administrator) were n Jeopardy on 2-26-14 The surveyor confirmer	<ul> <li>n. Z1 (R4's Physician)</li> <li>d have been placed in 1:1</li> <li>suffocating R5. Z1 stated</li> <li>g to the facility 1-08-14, R4</li> <li>" and had been admitted to</li> <li>to have R4's medications</li> <li>'I suppose (R4) could have</li> <li>er residents"</li> </ul> Assessment (MDS) dated <ul> <li>hat R5 is severely cognitively</li> <li>al dependence of two or</li> <li>is, bed mobility. The MDS</li> <li>: R5 did not ambulate.</li> </ul> dated 2-25-14 and signed <ul> <li>documents that at the time</li> <li>lents resided in the facility.</li> <li>d E4 (Corporate</li> <li>otified of the Immediate</li> </ul>	F 226		DEFICIENCY)		
		ohibition policy was ced to E1 (Administrator) ursing) by E3 (Corporate					
	staff by E3. All remain	in-serviced to all working					

Facility ID: IL6012157

If continuation sheet Page 21 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/10/2014 MAPPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		145674	B. WING		_		C 06/2014
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
LEROY M	ANOR			09 SOUTH BUCK ROAD, I E ROY, IL 61752	PO BOX 149		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page facility for work. 3. All interviewable re interviewed for approp	esidents are being priate roommates and	F 226				
	ensuring continued co responsible for overse the Plan of Abatemen	shall be responsible for ompliance and will be eeing the implementation of t.					
F 490 SS=F	<ol> <li>A Quality Assurance implemented under the (Administrator) or Dest compliance.</li> <li>483.75 EFFECTIVE ADMINISTRATION/R</li> </ol>	ne supervision of E1	F 490				
	enables it to use its re efficiently to attain or	mental, and psychosocial					
	by: Based on observation review the facility faile with knowledge of the resident to resident as residents (R4, R5) rev	viewed for abuse in the nas the potential to affect all					
	Findings include:						
	A facility Abuse Prohil	pition Policy dated as					

Facility ID: IL6012157

If continuation sheet Page 22 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES			I	NTED: 03/10/2014 FORM APPROVED B NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3)	) DATE SURVEY COMPLETED
		145674	B. WING			C 03/06/2014
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZI	P CODE	
LEROY M	ANOR			09 SOUTH BUCK ROAD, PO BO E ROY, IL 61752	X 149	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	(X5) COMPLETION DATE
F 490	increased the residen or others or being the behaviors would inclu aggressive behaviors entering other resider communication disorce heavy nursing care ar on staff." The policy a administration shall in enforcement authoritie physical abuse." The following an incident of Administrator shall tal protect all residents in the alleged perpetrator that, "the suspected supervised 1:1 or kep all other residents unt indicates that, "The sl resident's attending p On 2-26-14 at 2:45p.r head and shrugged sl the facility abuse pohi that E1 was not sure outlined in the facility'	ments that, "Special to identifying behavior that t's potential for abusing self victim of abuse. These de residents with behaviors such as; nts roomsresidents with ders, and those who require nd/ or are totally dependant also documents that, "The nmediately contact local law es," for resident to resident policy documents that of alleged abuse, "the ke all steps necessary to a the facility from abuse until or can be evaluated," and I resident shall be t physically separated from il further orders." The policy nift nurse shall call the	F 490			
	situation, stating, "I do says). I haven't read about what situations notification E1 replied harm?" A Facility Data Sheet by E1 (Administrator)	hon't know (what the policy it for a while." When asked require law enforcement , "I don't know. Physical dated 2-25-14 and signed documents that at the time ents resided in the facility.				

If continuation sheet Page 23 of 24

		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES					). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR	RUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		145674	B. WING	B. WING			06/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
LEROY M				509 SOUT	TH BUCK ROAD, PO BOX 149		
	ANUR			LE ROY,	, IL 61752		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	K	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
170					DEFICIENCY)		

Event ID: DVSB11

Facility ID: IL6012157

If continuation sheet Page 24 of 24

PRINTED: 03/10/2014