STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING _____ B. WING _____	C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEROY MANOR	**509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Original Complaint Investigation 1460573/ IL#68021 - no deficiency 1460775/ IL#68303 F157, F223, F224, F226, F490 cited. A partial extended survey was conducted.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

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

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the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to promptly notify a resident's physician and Power of Attorney after a change in resident condition for two of two residents (R4, R5) reviewed for change in condition in a sample of five.

Findings include:

An abuse investigation dated 2-24-14 documents that on 2-23-14 at 1:00a.m., "(R4) was found lying on top of roommate (R5) with hands over mouth and nose."

On 2-26-14 at 10:50a.m. E15 (Certified Nurse Aide) stated that on 2-23-14 at around 1:00a.m. E15 and E18 (Certified Nurse Aide) were near the nurse's station when "yelling" could be heard from down the hall. E15 stated that E18 stopped for gloves while E15 went into R4's room and found R4 on top of R5 with hands covering R5's mouth and nose. E15 stated that after R4's hands were taken off of R5's mouth and nose, R5 was not responsive. E15 stated that both E15 and E18 started patting R5's face, rubbing R5's chest, and lifting R5's arms and legs to get R5 to respond. E15 stated, "It was a sight I will never forget. It was a very serious situation...It took me about an hour to calm down." E15 stated that R4 had a history of behaviors but had not physically harmed anyone before.

On 2-26-14 at 9:55a.m. E18 (Certified Nurse

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Aide) stated that on 2-23-14 at 1:00a.m. when E18 entered R4's room, E15 (Certified Nurse Aide) had already pulled R4's hands from R5's mouth and nose. E18 stated that R5 did not respond for 20-30 seconds. E18 stated, "I touched R5's face, and rubbed R5's chest... It took 20-30 seconds to arouse R5." E18 stated that R4 had a history of intrusive behaviors which included walking into other residents rooms without permission, "constantly drug seeking," and agitation. E18 stated that R4 had never physically harmed any one as far as E18 was aware.

On 2-26-14 at 9:18a.m. E12 (Licensed Practical Nurse) stated that on 2-23-14 at 1:00a.m. after R4 was found with hands covering R5's mouth and nose, R4 was removed from the room and taken to the nurse's station for supervision so E12 could telephone E1 (Administrator) for instructions. E12 verified that R4 and R5's physicians and families were not called after the incident because E1 told E12, "I'll take care of it in the morning." E12 stated, "I assumed that meant calling the doctor and the family too." E12 stated that a fax report was sent to R4 and R5's physician's office after the incident occurred, but that no one would have seen that fax until the office opened.

Nurse's notes dated 2-23-14 at 1:21a.m. documented, "(R5) slow to respond for 30 seconds after incident. (E1) notified of incident."

On 2-26-14 at 9:18a.m. E12 (Licensed Practical Nurse) stated that after the incident between R4 and R5, a fax regarding the incident was sent to the office of Z1 (R4 and R5's Physician) on 2-23-14 which was a Sunday.

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F 157	Continued From page 3 Nurse's notes for R5 dated 2-23-14 document that R5's physician was not verbally notified of the incident or R5's unresponsiveness following the incident until 10:01a.m., and R5's POA (Power of Attorney) was not notified until 12:13p.m., over 11 hours later. Nurse's notes for R4 dated 2-23-14 document R4's physician's office was notified of R4's behavior by fax on 2-23-14, which was a Sunday, and that R4's POA (Power of Attorney) was notified by phone at 9:50a.m., over eight hours after the incident occurred. A change in condition policy dated as revised 12/2002 documents, "Our facility shall promptly notify the resident, and/or resident's representative, and his or her attending physician of changes in the resident's condition and/or status."	F 157		
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 follow their policy and provide for the safety of other residents after	F 223		

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resident to resident abuse occurred, and failed to notify law enforcement of an assault of one resident (R5) by another resident (R4). R4 attempted to suffocate R5, a severely cognitively impaired resident, R5 was not placed on one to one observation as specified in the facility policy, which placed other residents at risk. These failures have the potential to affect all 80 residents in the facility. These failures resulted in an Immediate Jeopardy.

While the Immediate Jeopardy was removed on 2-26-14, the facility remains out of compliance at a severity level two as the facility is still educating management and staff on the Abuse Prohibition policy.

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 attempting to suffocate 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

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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.

On 2-26-14 at 9:18a.m. E12 (Licensed Practical Nurse) stated that on 2-23-14 after R4 was found with hands covering R5's mouth and nose, R4 was removed from the room and taken to the nurse's station for supervision so E12 could telephone E1 (Administrator). E12 verified that R4 and R5's physicians and families were not called after the incident because E1 told E12, "I'll take care of it in the morning." E12 stated, "I assumed that meant calling the doctor and the family too." E12 stated that during the conversation with E1, E1 was informed that the facility did not have enough staff to keep R4 in 1:1 observation and that E1 stated, "I didn't say 1:1, I said to monitor (R4) closely." E12 stated that during the conversation with E1, E1 also stated, "I already talked to R4's son about R4 and said one more incident and R4 would have to go." E12 verified that following the phone call with E1, R4 was transferred to a private room on another unit in the facility.

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On 2-26-14 at 10:50a.m. E15 (Certified Nurse Aide) stated that on 2-23-14 at around 1:00a.m. E15 and E18 (Certified Nurse Aide) were near the nurse's station when "yelling" could be heard from down the hall. E15 stated that E18 stopped for gloves while E15 went into R4's room and found R4 on top of R5 with hands covering R5's mouth and nose. E15 stated that once R4 was pulled off of R5, E12 (Licensed Practical Nurse) entered the room and asked R4 if R4 was aware that covering another resident's nose and mouth, keeping them from breathing, could cause serious harm. E15 stated that R4 verified understanding what R4 had done. E15 stated that after R4's hands were taken off of R5's mouth and nose, R5 was not responsive. E15 stated that both E15 and E18 started patting R5's face, rubbing R5's chest, and lifting R5's arms and legs to get R5 to respond. E15 stated, "It was a sight I will never forget. It was a very serious situation...It took me about an hour to calm down."

On 2-26-14 at 9:55a.m. E18 (Certified Nurse Aide) stated that when E18 entered R4's room on2-23-14 at 1:00a.m., E15 (Certified Nurse Aide) had already pulled R4's hands from R5's mouth and nose. E18 stated that R5 did not respond for 20-30 seconds. E18 stated, "I touched R5's face, and rubbed R5's chest... It took 20-30 seconds to arouse R5." E18 stated that R4 had a history of intrusive behaviors which included walking into other residents rooms without permission, "constantly drug seeking," and agitation. E18 stated, "We spent a lot of time baby sitting R4 because of R4's behaviors."

On 2-26-14 at 9:00a.m. E17 (Licensed Practical

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Nurse) stated that 2-23-14 after the incident between R4 and R5, R4 was transferred to E17's care at the end of the hall. E17 stated that when R4 arrived to the new room, R4 was "agitated." E17 verified, "No one sat with R4. We were very limited with staffing and I couldn't pull someone to sit with R4. So between the two CNAs (Certified Nurse Aides) and I, we checked on R4 every 15 minutes."

On 2-26-14 at 1:35a.m. E13 (Certified Nurse Aide) stated that on 2-23-14 after the incident, R4 was transferred to the 100 hall where E13 was working. E13 stated that because there was not enough staff available to watch R4, E13 and E14 (Certified Nurse Aide) took turns monitoring R4 every 15 minutes. E13 stated that they decided to block the bathroom from the adjacent room to R4 so R4 could not gain access to that resident's room.

On 2-26-14 at 2:35p.m. E10 (Licensed Practical Nurse) verified that E10 telephoned E1(Administrator) the morning of 2-23-14 just before 10:00a.m. because E1 had not arrived at the facility to decide what to do about R4. E10 stated that while talking to E1, E1 denied any memory of being called by E12 (Licensed Practical Nurse) after the incident occurred between R4 and R5. E10 stated during the conversation with E1, E10 was instructed to notify R4 and R5's physician of the incident, but that E1 also stated R4 and R5's families would be informed once E1 arrived at the facility. E10 stated that R4's physician instructed E10 to transfer R4 to the hospital for evaluation. E10 stated the police were not notified of the resident to resident assault until after 10:00a.m., over nine hours after the incident, when R4 was transferred

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to the hospital. E10 noted that the police were only notified at that time to protect the safety of the emergency medical technicians transporting R4 to the hospital for a psychiatric evaluation.

On 2-26-14 at 2:45p.m. E1 (Administrator) shook head and shrugged shoulders when asked about the facilty abuse prohibition policy. E1 verified that E1could not state what procedures were outlined in the facility's abuse policy, or what actions should be taken following a witnessed abuse situation, stating, "I don't know (what the policy says). I haven't read it for a while." When asked about what situations require law enforcement notification E1 replied, "I don't know. Physical harm?" E1 verified that the facility had had discussions with R4's POA (Power of Attorney) about transferring R4 to a different facility. E1 stated, "I'm sure we talked to (R4's) son about how to make R4 happy, and that might have involved going to another facility."

On 2-26-14 at 1:25p.m. E16 (Social Services Director) stated that R4 had had several room changes since arriving at the facility 1-08-14. E16 stated that R4 didn't like roommates who made noise, left lights on, or had visitors. E16 stated that it was E16 who determined that placing R4 and R5 in the same room would, "be a good fit." E10 stated that because R5 was quiet and didn't watch TV, "I didn't think it would be a risk to put R4 in a room with R5"

On 2-26-14 at 2:20p.m. Z1 (R4's Physician) verified that R4 should have been placed in 1:1 supervision following trying to suffocate R5. Z1 stated that prior to R4 coming to the facility 1-08-14, R4 had "psych behaviors" and had been admitted to an acute care facility to have R4's

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medications adjusted. Z1 stated, "I suppose (R4) could have been a danger to other residents..."

A Minimum Data Set Assessment (MDS) dated 1-07-14 documents that R5 is severely cognitively impaired requiring total dependence of two or more staff for transfers and bed mobility. The MDS also documented that R5 did not ambulate.

E1 (Administrator) and E4 (Corporate Administrator) were notified of the Immediate Jeopardy on 2-26-14 at 3:30p.m.

A Facility Data Sheet dated 2-25-14 and signed by E1 (Administrator) documents that at the time of the survey 80 residents resided in the facility.

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

1. Facility's Abuse Prohibition policy was reviewed and in-serviced to E1 (Administrator) and E2 (Director of Nursing) by E3 (Corporate Nurse).

2. Facility's Abuse Prohibition policy and notification policy was in-serviced to all working staff by E3. All remaining staff will receive in-servicing on the policy as they report to the facility for work.

3. All interviewable residents are being interviewed for appropriate room mates and feeling safe in their environment.

4. The Administrator shall be responsible for ensuring continued compliance and will be

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F 223	Continued From page 10 responsible for overseeing the implementation of the Plan of Abatement. 5. A Quality Assurance Program will be implemented under the supervision of E1 (Administrator) or Designee to monitor for compliance.	F 223		
F 224 SS=L	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility neglected to have knowledge of and enact their policy on resident to resident abuse. This resulted in inadequate monitoring of one resident (R4) after R4 attempted to suffocate the roommate (R5). The facility neglected to notify law enforcement immediately after the resident to resident assault. These failures have the potential to affect all 80 residents in the facility. This resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 2-26-14, the facility remains out of compliance at a severity level two as the facility is still educating management and staff on the Abuse Prohibition policy.	F 224		

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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.

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On 2-26-14 at 10:20a.m. E15 (Certified Nurse Aide) stated that during the early morning hours of 2-23-14 around 1:00a.m. R4 was found on top of R5 with hands over R5's mouth and nose attempting to suffocate R5.

On 2-26-14 at 9:18a.m. E12 (Licensed Practical Nurse) stated that when E1 (Administrator) was notified of the assault on R5 by R4, E12 was instructed to move R4 to another room and to "monitor closely." E12 understood that E1 wanted R4 and R5's POAs (Power of Attorney) and physicians to be notified once E1 came to the facility later that morning. E12 stated that during the conversation with E1, E1 also stated, "I already talked to R4's son about R4 and said one more incident and R4 would have to go."

On 2-26-14 at 9:55a.m. E18 (Certified Nurse Aide) stated that R4 had a history of intrusive behaviors which included walking into other residents rooms without permission, "constantly drug seeking," and agitation.

On 2-26-14 at 1:35a.m. E13 (Certified Nurse Aide) stated that in order to keep R4 from entering the resident's room adjacent to R4's, E13 and E14 (Certified Nurse Aide) used a wheelchair to block the bathroom door.

On 2-26-14 at 1:25p.m. E16 (Social Services Director) stated that R4 was placed in the same room R5 because R5 was quiet, didn't watch TV, and E16 didn't think there was any risk.

On 2-26-14 at 2:35p.m. E10 (Licensed Practical Nurse) stated that R4 and R5's physician was

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LEROY MANOR	509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752

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notified of the assault over eight hours after it occurred, and that law enforcement was only notified to provide safety to emergency medical technicians while transporting R4 to the hospital.

On 2-26-14 at 11:35a.m. E2 (Director of Nurses) stated that E2 takes over responsibilities of the Abuse Coordinator when E1 is unavailable. E2 stated that after arriving at the facility 2-23-14 at around 9-9:30a.m E2 did check to see if R4 was being supervised by staff. E2 verified that R4 was not being supervised one to one. E2 verified that law enforcement was only called to assist emergency medical technicians with transporting R4 to the hospital.

On 2-26-14 at 2:45p.m. E1 (Administrator) shook head and shrugged shoulders when asked about the facility abuse prohibition policy. E1 verified that E1 could not recall what procedures were outlined in the facility's abuse policy or what actions should be taken following a witnessed abuse situation, stating, "I don't know (what the policy says). I haven't read it for a while." When asked about what situations require law enforcement notification E1 replied, "I don't know. Physical harm?" E1 verified that facility had had discussions with R4's POA (Power of Attorney) about transferring R4 to a different facility. E1 stated, "I'm sure we talked to (R4's) son about how to make R4 happy, and that might have involved going to another facility.

On 2-26-14 at 2:20p.m. Z1 (R4's Physician) verified that R4 should have been placed in 1:1 supervision following suffocating R5. Z1 stated that prior to R4 coming to the facility 1-08-14, R4 had "psych behaviors" and had been admitted to an acute care facility to have R4's medications

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adjusted. Z1 stated, "I suppose (R4) could have been a danger to other residents..."

A Facility Data Sheet dated 2-25-14 and signed by E1 (Administrator) documents that at the time of the survey 80 residents resided in the facility.

E1 (Administrator) and E4 (Corporate Administrator) were notified of the Immediate Jeopardy on 2-26-14 at 3:30p.m.

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

1. Facility's Abuse Prohibition policy was reviewed and in-serviced to E1 (Administrator) and E2 (Director of Nursing) by E3 (Corporate Nurse).

2. Facility's Abuse Prohibition policy and notification policy was in-serviced to all working staff by E3. All remaining staff will receive in-servicing on the policy as they report to the facility for work.

3. All interviewable residents are being interviewed for appropriate room mates and feeling safe in their environment.

4. The Administrator shall be responsible for ensuring continued compliance and will be responsible for overseeing the implementation of the Plan of Abatement.

5. A Quality Assurance Program will be implemented under the supervision of E1 (Administrator) or Designee to monitor for

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F 224	Continued From page 15 compliance.	F 224		
F 226 SS=L	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their abuse policy by not placing a resident (R4), alleged to have committed physical abuse, either in 1:1 supervision or kept physically separate from all other residents, failed to notify the victim (R5) and the perpetrator (R4's) physician for a period of nine hours after the incident occurred, and failed to contact law enforcement regarding the alleged physical abuse. The facility also failed to follow it's abuse policy by identifying R4's intrusive behavior as potentially leading to abuse and failed to identify R5's severe cognitive impairment and total dependence on staff as increasing the potential for being abused prior to making R4 and R5 roommates. These failures resulted in an Immediate Jeopardy which affected had the potential to affect all 80 residents in the facility. While the Immediate Jeopardy was removed on 2-26-14, the facility remains out of compliance at a severity level two as the facility is still educating management and staff on the Abuse Prohibition policy.	F 226		

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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.

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On 2-26-14 at 9:18a.m. E12 (Licensed Practical Nurse) stated that on 2-23-14 after R4 was found with hands covering R5's mouth and nose, R4 was removed from the room and taken to the nurse's station for supervision so E12 could telephone E1 (Administrator). E12 verified that R4 and R5's physicians and families were not called after the incident because E1 told E12, "I'll take care of it in the morning." E12 stated, "I assumed that meant calling the doctor and the family too." E12 stated that during the conversation with E1, E1 was informed that the facility did not have enough staff to keep R4 in 1:1 observation and that E1 stated, "I didn't say 1:1, I said to monitor (R4) closely." E12 stated that during the conversation with E1, E1 also stated, "I already talked to R4's son about R4 and said one more incident and R4 would have to go." E12 verified that following the phone call with E1, R4 was transferred to a private room on another unit in the facility.

On 2-26-14 at 10:50a.m. E15 (Certified Nurse Aide) stated that on 2-23-14 at around 1:00a.m. E15 and E18 (Certified Nurse Aide) were near the nurse's station when "yelling" could be heard from down the hall. E15 stated that E18 stopped for gloves while E15 went into R4's room and found R4 on top of R5 with hands covering R5's mouth and nose. E15 stated that once R4 was pulled off of R5, E12 (Licensed Practical Nurse) entered the room and asked R4 if R4 was aware that covering another residents nose and mouth, keeping them from breathing, could cause serious harm. E15 stated that R4 verified understanding what R4 had done. E15 stated that after R4's hands were taken off of R5's mouth and nose, R5 was not responsive. E15

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stated that both E15 and E18 started patting R5's face, rubbing R5's chest, and lifting R5's arms and legs to get R5 to respond. E15 stated, "It was a sight I will never forget. It was a very serious situation...It took me about an hour to calm down."

On 2-26-14 at 9:55a.m. E18 (Certified Nurse Aide) stated that on 2-23-14 when E18 entered R4's room, E15 (Certified Nurse Aide) had already pulled R4's hands from R5's mouth and nose. E18 stated that R5 did not respond for 20-30 seconds. E18 stated, "I touched R5's face, and rubbed R5's chest... It took 20-30 seconds to arouse R5." E18 stated that R4 had a history of intrusive behaviors which included walking into other residents rooms without permission, "constantly drug seeking," and agitation. E18 stated, "We spent a lot of time baby sitting R4 because of R4's behaviors."

On 2-26-14 at 9:00a.m. E17 (Licensed Practical Nurse) stated that after the incident between R4 and R5, R4 was transferred to E17's care in a room at the end of the hall. E17 stated that when R4 arrived to the new room, R4 was "agitated." E17 verified, "No one sat with R4. We were very limited with staffing and I couldn't pull someone to sit with R4. So between the two CNAs (Certified Nurse Aides) and I, we checked on R4 every 15 minutes."

On 2-26-14 at 2:35p.m. E10 (Licensed Practical Nurse) verified that E10 telephoned E1 the morning of 2-23-14 when E1 had not arrived at the facility to decide what to do about R4. E10 stated that while talking to E1, E1 denied any memory of being called during the night after the incident occurred between R4 and R5. E10

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stated during the conversation with E1, E10 was instructed to notify R4 and R5's physician of the incident but that E1 stated R4 and R5's families would be called once E1 arrived at the facility. E10 stated that once the facility received an order from R4's physician to transfer R4 to the hospital, an ambulance was called. E10 stated that the police were notified that R4 was transferring to the hospital, which is customary as a safety precaution for the emergency medical technicians transporting R4 to the hospital for a psychiatric evaluation.

On 2-26-14 at 2:45p.m. E1 (Administrator) shook head and shrugged shoulders when asked about the facility abuse prohibition policy. E1 verified that E1 was not sure what procedures were outlined in the facility's abuse policy or what actions to take following a witnessed abuse situation, stating, "I don't know (what the policy says). I haven't read it for a while." When asked about what situations require law enforcement notification E1 replied, "I don't know. Physical harm?" E1 verified that facility had had discussions with R4's POA (Power of Attorney) about transferring R4 to a different facility. E1 stated, "I'm sure we talked to (R4's) son about how to make R4 happy, and that might have involved going to another facility.

On 2-26-14 at 1:25p.m. E16 (Social Services Director) stated that R4 had had several room changes since arriving at the facility 1-08-14. E16 stated that R4 didn't like roommates who made noise, left lights on, or had visitors. E16 stated that it was E16 who determined that putting R4 and R5 in the same room would, "be a good fit." E10 stated that because R5 was quiet and didn't watch TV, "I didn't think it would be a risk to put

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R4 in a room with R5"

On 2-26-14 at 2:20p.m. Z1 (R4's Physician) verified that R4 should have been placed in 1:1 supervision following suffocating R5. Z1 stated that prior to R4 coming to the facility 1-08-14, R4 had "psych behaviors" and had been admitted to an acute care facility to have R4's medications adjusted. Z1 stated, "I suppose (R4) could have been a danger to other residents..."

A Minimum Data Set Assessment (MDS) dated 1-07-14 documents that R5 is severely cognitively impaired requiring total dependence of two or more staff for transfers, bed mobility. The MDS also documented that R5 did not ambulate.

A Facility Data Sheet dated 2-25-14 and signed by E1 (Administrator) documents that at the time of the survey 80 residents resided in the facility.

E1 (Administrator) and E4 (Corporate Administrator) were notified of the Immediate Jeopardy on 2-26-14 at 3:30p.m.

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

1. Facility's Abuse Prohibition policy was reviewed and in-serviced to E1 (Administrator) and E2 (Director of Nursing) by E3 (Corporate Nurse).

2. Facility's Abuse Prohibition policy and notification policy was in-serviced to all working staff by E3. All remaining staff will receive in-servicing on the policy as they report to the

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F 226	Continued From page 21 facility for work. 3. All interviewable residents are being interviewed for appropriate roommates and feeling safe in their environment. 4. The Administrator shall be responsible for ensuring continued compliance and will be responsible for overseeing the implementation of the Plan of Abatement. 5. A Quality Assurance Program will be implemented under the supervision of E1 (Administrator) or Designee to monitor for compliance.	F 226		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to administer the facility with knowledge of the abuse policy specific to resident to resident assault for two of three residents (R4, R5) reviewed for abuse in the sample of five. This has the potential to affect all 80 residents in the facility. Findings include: A facility Abuse Prohibition Policy dated as	F 490		

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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."

On 2-26-14 at 2:45p.m. E1 (Administrator) shook head and shrugged shoulders when asked about the facility abuse pohibition policy. E1 verified that E1 was not sure what procedures were outlined in the facility's abuse policy or what actions to take following a witnessed abuse situation, stating, "I don't know (what the policy says). I haven't read it for a while." When asked about what situations require law enforcement notification E1 replied, "I don't know. Physical harm?"

A Facility Data Sheet dated 2-25-14 and signed by E1 (Administrator) documents that at the time of the survey 80 residents resided in the facility.

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