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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERNATIONAL NURSING & REHAB CENTER	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

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F 000	INITIAL COMMENTS Annual Licensure and Certification.	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive plan of care appropriate for the care needs of six of 24 residents (R1, R3, R6, R7, R10, and R15) reviewed for care plans in the sample of 24. The facility also failed to revise and implement new individualized approaches or interventions as the resident's medical status changed. Findings include:	F 280		

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

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1. Based on R1's Minimum Data Set (MDS) dated 5/16/2013 under Functional Status R1 scored:
Bed mobility - 3/2(extensive assistance/one person physical assist)
Transfer - 3/3 (extensive assistance/two+ persons physical assist)
Dressing - 3/2 (extensive assistance/one person physical assist)
Eating - 2/2 (limited assistance/one person physical assist)
Toilet use - 3/3 (extensive assistance/two+ persons physical assist)
Personal hygiene - 3/2 (extensive assistance/one person physical assist)
R1's quarterly care plan dated 5/9/2013 does not address bed mobility, transfers, dressing, and personal hygiene.
R1's Physician's Order Sheet (POS) denotes 7/8/2013 "discharge straight catheter every shift ...change urinary bag monthly and prn (as needed)." On 7/15/2013" indwelling urinary catheter care every shift, indwelling urinary catheter French #18, with 10mL balloon." E24 (MDS and Care Plan Coordinator) stated, "R1's urinary status states she is incontinent. She may have a foley now but her next care plan update is not due until August."
R1's care plan was not updated to address indwelling urinary catheter care.
2. According to R6's Minimum Data Set (MDS) dated 7/6/2013 under Functional Status R6 scored:
Bed mobility - 2/2 (limited assistance/one person physical assist)
Transfer - 2/3 (limited assistance/two+ persons physical assist)
Dressing - 2/2 (limited assistance/one person physical assist)
Eating - 0/1 (independent/setup help only)

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Toilet use - 2/2 (limited assistance/one person physical assist)
Personal hygiene - 2/2 (limited assistance/one person physical assist)
R6's quarterly care plan dated 6/30/2013 does not address bed mobility, transfers, dressing, toileting and personal hygiene.
3.According to R7's Minimum Data Set (MDS) dated 5/22/2013 under Functional Status R7 scored:
Bed mobility - 3/3 (extensive assistance/two+ persons physical assist)
Transfer - 3/3 (extensive assistance/two+ persons physical assist)
Dressing - 4/2 (total dependence/one person physical assist)
Eating - 4/2 (total dependence/one person physical assist)
Toilet use - 4/2 (total dependence/one person physical assist)
Personal hygiene - 4/2 (total dependence/one person physical assist)
R7's quarterly care plan dated 5/16/2013 does not address bed mobility, transfers, dressing, toileting and personal hygiene.
4. According to R15's Minimum Data Set (MDS) dated 6/4/2013 under Functional Status R15 scored:
Bed mobility - 4/3 (total dependence/two+ persons physical assist)
Transfer - 4/3 (total dependence/two+ persons physical assist)
Dressing - 4/2 (total dependence/one person physical assist)
Eating - 4/2 (total dependence/one person physical assist)
Toilet use - 4/3 (total dependence/ two+ persons physical assist
Personal hygiene - 4/2 (total dependence/one

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F 280	Continued From page 3 person physical assist) R15 scored 3 under urinary incontinence. A score of 3 means always incontinent. R15's quarterly care plan dated 6/12/2013 does not address bed mobility, transfers, dressing, toileting and personal hygiene. R15's careplan was updated on 7/24/2013 which denotes: total incontinence management. Problem: Incontinent of urine at unpredictable times throughout the day. Related to: Lack of awareness that bladder is filling or full. Severe cognitive impairment and memory recall, inability to make daily decisions, Diabetes and CVA (Cerebrovascular Accident). Manifested by: continuous loss of urine at unpredictable times. On 7/24/2013 at 12:40pm, E23 (Restorative Nurse) said during interview that she is responsible for updating care plans quarterly and when there are any changes. Restorative is responsible for updating bathing, transfers, passive range of motion (PROM), walking, eating, bed mobility and falls. E23 stated, "I updated R15's care plan this morning because on 3/8/2013 there was nothing there to address restorative care. There's also nothing on restorative for R1's, R6's and R7's care plans-they have not been updated, I've been in the hospital and I just came back this week. Nursing was covering for me while I was gone." Based on the facility's Care Plan Policy, "All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. Care plans are reviewed and discussed individually. Concerns, problems, needs, and/or strengths are listed based on resident's individual needs. Physician's orders and personal care and nursing needs are also listed based upon comprehensive assessments.	F 280		

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When a change occurs in a resident's condition the Resident Care Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated. The Resident Care Coordinator reads report books and makes rounds daily and updates care plans as needed. All interdisciplinary Team departments are responsible for charting that reflects the care plan concerns, problems, needs and/or strengths, approaches, progress or lack of progress with possible reasons for and any new problems." This policy was not followed.
5. R10 is a 81 year old resident with diagnoses including Alzheimer's disease and new onset seizures.

On 7/22/13 during the initial tour of the 3rd floor, surveyor was accompanied by E3 (director of nursing). While touring the east wing of the 3rd floor, R10 was noted in a wheeled recliner which was across from the dining/day room.

The progress note dated 4/26/13 (1:48PM) indicates R10 had a oxygen saturation of 84-87%, noted to have continuous jerking movement for approximately 30 seconds. R10 then went into a deep sleep, unable to arouse, breathing. Oxygen saturation 84-87%. R10 placed in bed, placed on oxygen via rebreather mask at 8 liters. E4 (assistant director of nursing) instructed nurse to call 911. R10 was sent out to the hospital.

On 4/30/13, R10 returned to the facility with a new diagnosis of New Onset Seizures.

Review of the most recent care plans dated 7/20/13 does not address this new onset of seizures diagnosis. The careplan presented

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F 280	Continued From page 5 7/25/13 does not list realistic approaches from social services. R10 is non verbal and has cognitive impairment. R10 is not able to vent or learn relaxation techniques or participate in activities. 6. R3 is a 66 year old resident with diagnoses including dementia without behaviors and depressive disorder. R3 has a history of conjunctivitis (11/10/12) and a history of MRSA (methicillin resistant staphylococcus aureus) of the nares (4/21/13). According to the nurse's notes R3 was placed on isolation precautions each time until being cleared of both infections. Review of the careplans from November 2012 through May 2013 did not indicate these two infections were addressed in the careplan.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one resident (R10) out of eight residents reviewed for range of motion in the sample of 24 residents was properly assessed for the appropriate splints to the upper extremities to prevent further decline as well as	F 318		

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not obtaining physician's orders for applying splints or devices to the upper extremities.

Findings include:

R10 is a 81 year old resident with diagnoses including Alzheimer's disease, osteoarthritis and osteoporosis.

On 7/22/13 during the initial tour of the 3rd floor, surveyor was accompanied by E3 (director of nursing). While touring the east wing of the 3rd floor, R10 was noted in a wheeled recliner which was across from the dining/day room. R10 did not have a splint or hand roll on the right or left hand.

During random observations on the 3rd floor from 2:00pm to 4:00pm, R10 was noted seated in a wheeled recliner in the east hall, across from the dining/day room. R10 did not have a splint or device on the right or left upper extremities.

On 7/23/13 during the lunch meal observation on the 3rd floor, R10 was seated in a wheeled recliner in the same area on the east hallway across from the dining room. R10 had a splint on the left upper extremity.

The May 2013, June 2013 and July 2013 POS (physician's order sheet) do not show orders for the application of splints or devices for R10's upper extremities.

On 7/24/13 at 12:37pm in the conference room, E23 (Director of Restorative) stated, "the restorative staff put splints on. She (R10) has one on her hand. It's on when she's awake and out of bed, during meals, activities and bedtime." When E23 was asked if she was aware that R10 is fed

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via G-tube (gastrostomy), E23 stated, "oh no, I apologize, I was thinking about someone else. She (R10) has hers on when up and off at bedtime."

Surveyor asked E23 to show the electronic restorative notes in the computer from July 2012 through July 2013. E23 stated, "It's not there. The notes are not there. I only see up to April through June 2012."

E23 tried to isolate restorative notes from January 2013 through July 2013. The restorative notes did not show up in the computer.

On 7/24/13 at 1:10pm, surveyor and E23 reviewed R10's clinical record on the 3rd floor Dementia unit. E23 acknowledged there were no orders for the application of splints or devices to R10's upper extremities.

On 7/24/13 at approximately 1:15pm, R10 was noted in the east hall on the 3rd floor seated in a wheeled recliner. R10 had a blue device on her right hand. All of the finger and thumbs on both hands were noted to be swollen. When E23 touched R10's right hand, R10 grimaced and slightly pulled her hand away. When E23 asked R10 if that hurt, R10 mumbled "yeah".

When asked who applied the hand roll to the right hand E23 stated, "my restorative aide may have applied the hand roll. I'll ask her." The blue hand roll had cloth separators between the fingers. The elastic strap of the hand roll device had brown stain on it.

On 7/24/13 at 1:25pm, E25 (Certified Nurse Aide/Restorative) stated, "this morning the splint

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was soiled so I sent it to the laundry. I saw her hand was slightly closed so I put a hand roll on. She can open it. I didn't want it to close. Yes, she had a splint on yesterday."

The progress notes dated 6/4/13 indicates "left hand in splint". The approaches in the quarterly care plan dated 7/20/13 indicate the nurses are to coordinate physician's orders with therapy department...notify physician as appropriate, coordinate splint application with the restorative department. Nursing/Restorative staff apply wrist/grip splint(s) to left hands. Apply on day shift/remove 8 hours later as tolerated.

There are no orders on the July 2013 POS for the type of splint/device and the length of time the splint/device should be worn.

On 7/24/13 at 2:45pm, E23 presented to the survey team the Restorative Nursing Assessment. The first page does not have dates for the initial and quarterly assessments. The assessment indicates for the right and left hand, R10 has limited ability. R10 is totally dependent on staff for all ADLs (activities of daily living). In the area of splints or braces it lists left hand splint.
This assessment does not indicate what the facility is doing to prevent further decline for R10's right and left upper extremities.

The Reentry MDS (minimal data set) dated 6/2/13, indicates in the area of functional limitation in range of motion, R10 was scored 2/2 indicating impairment on both sides with the upper and lower extremity.

On 7/25/13 during the facility's presentation to the

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F 318	Continued From page 9 survey team, there were no physician's orders presented regarding the application of the splints or devices for R10.	F 318		
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	F 441		

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transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure hand hygiene and proper storage of urinals for 5 of 6 (R1,R5,R9,R12,R16,) residents reviewed for infection control in the sample of 24 and for 6 residents (R25,R26,R27, R28,R29, and R30) in the supplemental sample.
Findings include:
1. On 7/22/13 at 2:00pm E10 Certified Nursing Assistant (CNA) and E11 (CNA) changed R16. E11 tossed the garbage and did not perform any hand hygiene. At 2:35pm E13 Certified Nurse Assistant (CNA) tossed a bag of garbage in the utility room and did not perform any hand hygiene.

2. During 2 days of the survey on 7/22/2013 and 7/23/2013, R1's urinary drainage bag was found on the floor.
On 7/22/13 at 10:00am, R29 had a urinal which contained urine located on the top of his bedside table. Next to the urinal were a cup of coffee, a carton of milk and a pitcher of water. E4 (Assistant Director of Nursing) removed the urinal, but R29 was in the restroom, so E4 placed the urinal back on the table.

On 7/23/2013 at 11:27am E27 (Certified Nursing Assistant/CNA) and E19 (CNA) were rendering care for R1. E19 donned gloves upon entering the room and did not wash her hands. E27 applied lotion to R1's right knee, changed her

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gloves and did not wash her hands. E27 then changed R1's urinary drainage bag to a leg bag, changed her gloves and did not perform hand hygiene. Both E19 and E27 placed an incontinence brief on R1, changed gloves again and did not perform hand hygiene. E27 went to R1's closet, grabbed a sweater, placed it on R1 then cleaned R1's glasses and placed them on R1 without hand hygiene. E19 proceeded to comb R1's hair. E19 then placed her gait belt on R1's furniture, placed it around R1's waist, assisted R1 to transfer from bed to chair then removed her gait belt from R1, and placed it back on E19's waist.
On 7/23/2013 at 11:30am, R12's urinal was observed on top of R12's dresser.
On 7/23/13 at 12:40 pm R26 had a full urinal by his bedside table.

3. On 7/23/13 at approximately 1:20pm, E21 (Certified Nursing Assistant/CNA) exited the bathroom of R27 with soiled linen in her bare hands. E21 stated she had just provided incontinence care for R27 and was going to dispose of the linen. E21 then walked to the soiled utility room, dumped the linen, walked to the nursing station and obtained a plastic bag from a drawer, all without performing hand hygiene.

On 7/23/13 at 1:30pm, E15 (CNA) and E21 (CNA) placed R9 in bed, and removed a soiled dressing from R9's sacral (buttocks) area. E15 then exited the room without performing hand hygiene and adjusted the wheelchair of R30.
4. On 7/23/13
At 12:30pm Z1 (phlebotomist) attempted to draw blood from R25. After an unsuccessful attempt Z1 took off the gloves and left R25 ' s room

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without performing hand hygiene. Z1 proceeded to R26's room and drew his blood. Z1 did not wash her hands before drawing the blood or after removing the gloves.
At 12:40 Z1 returned to R25's room with E8 (Registered Nurse) to draw blood. Z1 and E8 did not was their hands before putting on the gloves, upon leaving the room and after contact with R25.
At 12:50pm Z1 stated " Hand washing, I just washed them when I went to the bathroom. I use hand sanitizer that I carry with me. Z1 was unable to show surveyor the sanitizer she carries in her box.
I must have used it all. I had one with me. Hand washing I think it is for 10 seconds. "

At 1:00pm E16 (Restorative aide) left R28 ' s room with the mechanical lift. E16 was still wearing gloves when he exited the room. E16 took of the gloves as he saw the surveyor. E16 took the mechanical lift to the south shower room for storage. E16 then went down the hallway and never performed any hand hygiene.

At 2:33pm E26 and E19 were repositioning and assisting R25 to the bathroom. E19 did not perform any hand hygiene after removing the gloves and leaving R25 ' s room and before entering R28's room.

On 7/24/13
At 1:30pm E28 (Restorative Aide) stated " I use water, soap, lather for 20 to 25 seconds, sing the happy birthday to myself, rinse, use paper towel, dry, toss and with clean towel close faucet. "

At 2:00pm E8 stated " Hand washing takes about 10 seconds to wash hands. I use water, wash, rinse, paper towel. I wash them before and after

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rendering care to resident, after I go to the bathroom, before I set food, after and before I put gloves on. "

At 2:10pm E29, CN A stated " I use water, soap, sing happy birthday twice. Use paper to dry, tossed the paper and get a new one to close the faucet. I wash them for two (2) minutes.

On 7/25/13 at 8:30am E22 (Licensed Practical Nurse) LPN entered R5 ' s room to assist E21. E22 did not perform any hand hygiene before putting her gloves on to assist in repositioning R25. E22 took off the gloves and left the room to get a pad from the clean linen cart located in the hallway. E22 did not perform any hand hygiene.

On 7/25/2013 at 9:35am during the facility ' s presentation, E30 (Intern) stated that they performed an in-service regarding hand washing for their employees and reviewed their policy.

According to the facility ' s Hand Washing Policy, " All facility staff will practice hand washing activities with an anti-microbial agent or water-less antiseptic agent in accordance with this policy. Standards:
1. Hand washing will be practiced as follows: a. When hands are visibly soiled
b. Before and after resident contact
c. After contact with source of microorganisms (body fluids and substances, mucous membranes, non-intact skin, inanimate objects that are likely to be contaminated)
d. Immediately after glove removal
e. Between tasks and procedures on the same resident to prevent cross contamination of different body sites.
f. Before dispensing medications

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F 441	Continued From page 14 g. Before leaving the room of a resident in an isolation room h. After handling soiled linens i. Before handling food or food trays and after feeding a resident j. After handling bedpans, soiled urinals, collection specimens, or emptying or handling urinary drainage bags k. After using the bathroom 2. After coughing and sneezing or blowing and wiping nose 3. Alcohol based hand rubs may be used when hand washing facilities are not readily available, during scheduled medication administration passes and only when gross contamination has not occurred. The facility's handwashing policy documents: All facility staff will practice hand washing activities with an anti-microbial agent or waterless antiseptic agent in accordance with this policy. Standards: Handwashing will be practiced as follows: -Before and after resident contact. -After contact with source of microorganisms (body fluids and substances, mucous membranes, non-intact skin, inanimate objects that are likely to be contaminated). -Immediately after glove removal. -After handling soiled linen. 5. During this survey 7/22/13 to 7/24/13 the following facility staff had long nails: E3 Director of Nursing (DON), E4 Assistant director of nursing (ADON), E5, Social Services; E6 Activity director, E7 (LPN) supervisor, E9 Licensed practical nurse (LPN), E10 (CNA), E12 (CNA), E15 (CNA), E18 (CNA), E21 (CNA), E29	F 441		

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F 441	Continued From page 15 (CNA) and E26 Physical therapy assistant. On 7/25/13 at 1:45pm E3, (Director of Nursing) stated " The length of the nails..... well it should be like by your fingertip (pointed the thumb) since all of us wear nails." Facility Policy without a name and not dated documents under: Dress and Personal Appearance At this facility, we strive to maintain a relaxed yet professional atmosphere. Residents and guest frequently visit our facilities, so it is important for employees to dress in a neat and clean manner. Department Directors are responsible for establishing specific departmental standards for dress and personal appearance that are consistent with the intent of this policy and the following general guidelines: 6. All employees are expected to maintain proper hygiene. Fingernails must be clean and of reasonable length for infection control and resident safety purposes.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to provide accurate record information during the survey for 9 (R1, R2, R3, R4, R6, R7, R9, R10 and R15) residents in the sample of 24. This failure affected the plan of care of residents residing in this facility.
The facility did not include R4 ' s name on the list of residents with wounds presented to the team during the survey from July 22 through July 25, 2013.
R4 ' s care plan dated 7/22/13 does not address all of R4 ' s wounds sites on R4 ' s left leg, right thigh, left thigh and right leg. Z2 ' s documented device related wounds on 7/12/13 on left thigh 2.0 cm in length and 1.5 cm in width, right thigh 9.5 cm in length and 7.4 cm in width and left leg 7.0 cm in length and 1.0 cm in width.
Resident Census and Conditions of Residents (Form CMS-672) dated 7/22/13 completed by facility documents under:
D. Skin Integrity
F115-118 - indicate the number of residents with:
F115 4 Pressure ulcers (exclude stage I)
F116 Of the total number of residents with pressure ulcers excluding stage 1, how many residents had pressure ulcers on admission 4?
R4 ' s pressure ulcer was acquired in the facility.

Z2 (Wound Doctor) was interviewed on 7/25/13 at 12:30pm. Z2 stated that R4 ' s Stage 4 pressure ulcer on his left medial knee is a result of the device that was used for R4 ' s leg spasms. Z2 stated " It is like a shoe that does not fit. First, it starts as a blister and then it opens up. That is what happened with R4 ' s left knee wound. The

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device caused a blister and then the wound. " Z2 stated that he had no idea that R4 ' s left knee wound (facility acquired stage 4 measuring 7.0cm in length, 5.0 cm in width and 1.0cm in depth) would result from the device rubbing against R4 ' s knees.

R1 ' s quarterly care plan dated 5/9/2013 does not address bed mobility, transfers, dressing, and personal hygiene.
R1's care plan was not updated to address indwelling catheter care.
R6's quarterly care plan dated 6/30/2013 does not address bed mobility, transfers, dressing, toileting and personal hygiene.
R7's quarterly care plan dated 5/16/2013 does not address bed mobility, transfers, dressing, toileting and personal hygiene.
R15's quarterly care plan dated 6/12/2013 does not address bed mobility, transfers, dressing, toileting and personal hygiene.
Facility's Care Plan Policy not dated. "All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. Care plans are reviewed and discussed individually. Concerns, problems, needs, and/or strengths are listed based on resident's individual needs. Physician's orders and personal care and nursing needs are also listed based upon comprehensive assessments. When a change occurs in a resident's condition the Resident Care Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated. The Resident Care Coordinator reads report books and makes rounds daily and updates care plans as needed. All interdisciplinary Team departments are responsible for charting that reflects the care plan

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concerns, problems, needs and/or strengths, approaches, progress or lack of progress with possible reasons for and any new problems."
On 4/30/13, R10 returned to the facility with a new diagnosis of New Onset Seizures.
Review of the most recent care plans dated 7/20/13 does not address this new onset of seizures diagnosis. The care plan presented 7/25/13 does not list realistic approaches from social services. R10 is non-verbal and has cognitive impairment. R10 is not able to vent or learn relaxation techniques or participate in activities.

R3 has a history of conjunctivitis (11/10/12) and a history of MRSA (methicillin resistant staphylococcus aureus) of the nares (4/21/13). According to the nurse's notes R3 was placed on isolation precautions each time until being cleared of both infections.
Review of the care plans from November 2012 through May 2013 did not indicate these two infections were addressed in the care plan.

Facility's Isolation Tracking Log did not include R3. On 7/25/13 at 1:45pm E3 stated " I don ' t know what happened that was a logging mistake, or the system. "

Facility's weight list of residents was incomplete; R2 and R9 were not included.

Matrix was not accurate since the beginning of the survey. An update for two times was requested by the survey team.
The following Resident ' s lists did not have the correct room number of the residents.
-. Identified offenders.
-.Residents receiving dialysis.

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F 514	Continued From page 19 -.Residents who speak a language other than the dominat language of the facility.	F 514		