STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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	F 000		
F 225 SS=D	Annual Licensure and Recertification Survey 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the failed to report an allegation of abuse immediately to the Administrator, allowed a Certified Nurse Aide (CNA) to have direct contact with residents after potential abuse incident and failed to do a thorough investigation of allegation of abuse for 1 of 3 residents (R14) reviewed for abuse investigations in the sample of 15. Findings include: Record review of R14's Minimum Data Set (MDS) of 7/8/13 documents R14 has no cognitive impairment and behaviors. Facility IDPH (Illinois Department of Public Health) NOTIFICATION INCIDENT INVESTIGATION REPORT of 7/5/13 documents an Email note dated 7/2/13 at 1:26PM, from Z1 (R14's friend) to E3 (House Hold Manager) that Z1 had talked to E4, Social Worker, today around noon when Z1 was leaving the facility. "I was a little alarmed today at R14's reaction to a directive for lunch by one of the care givers. In short, she seemed to have the immediate need to get there and said this particular care giver gets "very cross with us" when they don't get there on time or choose to not go right at the time she comes. She also said that "some of the girls can be very mean when we don't do what they want." We were right in the middle of something (cell phone instructions) and she apologized and then said that they MUST go at that time to avoid the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 225	Continued From page 2	F 225		

workers getting angry. Now, I must say that I didn't feel this worker was particularly cross with them when she approached us about lunch, but she certainly doesn't give off the caring and nurturing feeling that I have come to expect from the staff at (facility). It was a different feel, but I would have really passed it up without further thought until R14 behaved so differently about the need to hustle there before anyone got angry..I just wanted to let you know what I spoke to E4 about...I was rather alarmed by R14's reaction to the care giver at noon inquiring about lunch. It was not R14's words, but her preoccupation and anxiety related to the directive the girl gave her that prompted my need to share with E4, and now with you..."

Facility's Corrective Action Report of of 7/4/13 documents E5, CNA, was given a final written warning.

An undated written statement by E9, Licensed Practical Nurse, was in the investigation folder for the above incident, stating E5 had come to her that morning stating E5 was having problems caring for R17 (R14's husband) because R14 was standing in front of E5 when E5 was attempting to wash and dress R17. E9 documented E5 has come to get her anytime she feels there is an issue with a resident. R9 documented she had not noticed E5 being physically or verbally aggressive with any residents.

During interview with E1, Administrator, on 10/24/13 at 2PM, E1 stated no other residents or staff were interviewed during the investigation. E1 stated E9 wrote the statement that is in the report at E5's request. E1 stated E3 spoke with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 225	Continued From page 3	F 225		

R14 and that was the only interviews conducted. On 10/24/13 at 2:45PM, E1 stated E5 was not suspended while they investigated. They get a hold of corporate and let them know what's going on and wait to hear back from them on how to proceed. On 10/24/13 at 3;30PM, E1 stated she wasn't informed of the above incident until 7/3/13. E1 stated E5 should have been suspended during the investigation.

During interview with E4 on 10/24/13 at 4:40PM, E4 stated she recalled a conversation with Z1, really quick comment of concern on household. E4 stated she did not want to step on E3's toes so Z1 stated she would follow up with E3. E4 stated she did not report the incident to E1 or E3.

During interview with E3 on 10/24/13 at 3:45PM, E3 stated he did not get Z1's email until 7/3/13 at around 7:15AM and told E1 of the concern around 10AM. E3 stated he did talk with R14 and she stated she didn't want to cause waves in the household. E1 was present and stated they had a previous issue with E5 and they thought they needed to look into it.

Record review of E5's personal file documents that on 11/16/12, E5 was given a written warning, for conduct/attitude, performance. "It was reported by a resident that this employee told her that she would be back shortly and proceeded to leave this resident on the toilet 1.5 hours. Resident stated that she was able to hear this employee speaking with another about other residents and laughing. Resident stated that she had in -fact turned on her call light."

Review of E5's time card documents E5 worked from 7:08AM to 11:18PM on 7/2/13 and 7:12AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 225	Continued From page 4 to 4:35PM on 7/3/13.	F 225		
F 226 SS=D	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 operationalize its Abuse Policy by not reporting an allegation of abuse immediately to the Administrator, allowing a Certified Nurse Aide (CNA) to have direct contact with residents after potential incidents of abuse, and delaying the initial investigation of abuse for 1 of 3 residents (R14) reviewed for abuse investigations in the sample of 15. Findings include: The facility Abuse/Neglect Prevention and Response Policy and Procedure of 2005 documents the following: "If the situation is of grave concern and an individual is identified as having been abusive or negligent, that individual will be suspended form duty until an investigation is completed... Throughout the entire investigative process, from report of the situation until final findings are documented, the staff member, resident or family who reports the possible abuse/neglect is to be treat in a protective, reassuring and gracious	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 226	Continued From page 5	F 226		

manner...Any allegation of abuse or neglect is to be reported to the Care Center Administrator or his/her designee by any employee or agent of the community when she/becomes aware of or suspects and incident. If an employee is suspected of resident abuse or neglect, she/he will be immediately restricted from any further contact with the resident pending outcome of the investigation...When indicated, the employee may be suspended from duty pending outcome of the investigation...The Administrator or designee will interview staff who may have observed or have knowledge of the alleged event..."

Facility IDPH (Illinois Department of Public Health) NOTIFICATION INCIDENT INVESTIGATION REPORT of 7/5/13 documents an Email note dated 7/2/13 at 1:26PM, from Z1 (R14's friend) to E3 (House Hold Manager) that Z1 had talked to E4, Social Worker, today around noon when Z1 was leaving the facility. The email documents Z1 had concerns about a CNA who was caring for R14 and Z1 wanted to also share the concerns with E3, Household Coordinator.

During interviews with E1, Administrator, E3 and E4 on 10/24/13 at 3:40PM, E4 confirmed she did not tell the Administrator of Z1's concerns that were expressed on 7/2/13. E4 stated she did not want to step on E3's toes so she asked Z1 to contact E4 about the concerns. E3 stated that Z1 sent him an Email on 7/2/13 but he wasn't in his office and didn't get it until 7:15AM on 7/3/13. E3 told E1 of the concerns around 10AM. E1 and E3 stated they did not talk to any staff or other residents during the investigation. E3 only talked to R14 and R14 didn't want to make waves. During interview with E1, E1 stated that E5 was given a last final written warning. E1 stated E5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 226	Continued From page 6 was not suspended during the investigation and was allowed to work with residents. E1 confirmed E5 should have been suspended during the investigation Record review of E5's time card shows she worked a double shift on 7/2/13 and worked on 7/3/13	F 226		
F 441 SS=F	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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 441	Continued From page 7 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interview, the facility failed to establish and maintain an ongoing Infection Control Program that adequately collects data to calculate and analyze all infection rates This has the potential to affect all of the 58 residents living in the facility. Findings include: 1. On 10/22/13 at entrance into the facility, E2, Director of Nursing (DON) was asked to provide the Infection Control Logs and provided information for July, August and September 2013 but no information for October, 2013. On 10/24/13 at 8:30am, the October 2013 log was requested and E2 stated she did not have it done yet but could put it together in a short amount of time. E2 stated the facility currently has no isolations and she usually pulls the log together at the end of the month. E2 identified herself as the Infection Control Designee. 2. Review of the logs for September 2013 reflect R3 and R7 to have had cultures with no results or organisms identified. The corrective action includes antibiotic use only. None of the other entries into the September, August and/or July	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 441	Continued From page 8	F 441		

2013 log which identify cultures being done include organisms or lack/of. The log also fails to include any infection other than those antibiotics were used for.

3. The October log identified a Clostridium Difficile(C. Diff) infection for R16 identified/cultured on 10/3/13 with Vancomycin ordered but includes no corrective action and/or measures taken to ensure prevention. Interview with E6 on 10/25/13 at 10:35am identified herself as the full time nurse on R16's hall and confirmed that R16 had cultured C. Diff and was placed on isolation for the duration of her antibiotic use. E6 looked on the EMar (Electronic Medication Administration Record) for the dates of R16's antibiotic use and then stated R16 must have been on isolation on 10/6/13 - 10/14/13. Telephone orders reviewed document that the Vancomycin was ordered on 10/4/13 and according to the EMar, was not started until 10/6/13. When asked what precautions were implemented, R6 stated they posted a sign on the door and placed a commode in the room for R16's husband, her room mate at that time. According to the lab results, the culture was collected on 10/1/13 and reported on 10/3/13, therefore isolation precautions were not implemented until 5 days after R16's diarhea was first identified.. E6 stated R16 was incontinent of bowel and bladder. E6 stated R16 saw the physician yesterday (10/24/13) and no reculture was ordered. E6 stated R16 is currently asymptomatic. R16's room was observed on 10/25/13 at 10:30am to no longer have any isolation equipment present. Interview with E7 and E8, Certified Nurses Aides (CNA's) on R16's hallway stated when asked if anyone had been on isolation precautions in the past few weeks, they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 441	Continued From page 9	F 441		

both identified R16 and when asked what precautions were taken, the both stated "We bagged her clothes separately."

According to the Progress Notes, the first entry regarding R16 diarrhea was entered at 10:45am on 10/1/13 and documented "Chronic Loose stools, Greasy, found smelling stools." At 9:48pm on 10/1/13, the progress note documents "no diarrhea or loose stools noted this shift. Small amt of stool collected for culture and placed in frig for pick up." There is no indication the facility took precautionary measures documented in the progress notes thru 10/3/13 when the lab results returned positive and no entries at all from 10/1/13 through 10/25/13 that the facility took preventative measures during the time R16 was symptomatic.

4. The Policy entitled "Care of the resident with C Difficile infection" dated 2/10/13 confirms residents with positive cultures for C Diff have procedure followed to prevent the spread of infections that include not only the nursing staff but housekeeping as well and that standard precautions are to be followed.

5. On 10/24/13 at 3:30pm, E2 acknowledged that the log was not documented more frequently than once a month but stated that she did include infection control in her weekly meetings with her unit managers and sometimes on a daily basis but did not document that information. E2 also agreed that the log included no information other than those residents receiving antibiotics. On the bottom of the October form, E2 had written "*plan to inservice next week regarding preventing the spread of infection during the flu season" and acknowledged that more frequent tracking other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	4101 WEST ILES AVENUE SPRINGFIELD, IL 62711

(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 441	Continued From page 10 than monthly would be necessary to more quickly identify infections of this sort. 6. On 10/25/13 at 12 noon, E2 stated she assumed they put the preventative measures in place for R16 when she cultured positive for C. Diff but wasn't able to say for sure and agreed that the measures should have been taken when R16 was first symptomatic and not wait until the culture returned positive. E2 agreed that the facility lacked the documentation to ensure that prevention methods were followed appropriately according to the policy. 7. Resident Census and Conditions of Residents, CMS 672, dated 10/23/13, documents that the facility has 58 residents living in the facility.	F 441		