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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Investigation of Incident of May 12, 2016 - IL85632. F223 and F323 Cited.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the results of the most recent standard survey and complaint investigation are placed in a readily accessible place. The facility failed to post a notice of the availability of the survey result. This has the potential to affect all 105 residents in the facility. The findings include: The Census and Condition Report (CMS 672) dated 05/17/16 shows the facility census at 105. During the environmental tour of the facility on 05/18/16, there was no notice of the availability of the survey result posted anywhere in the facility. The survey report was not located in a place	F 167		

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

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F 167	Continued From page 1 readily accessible to the residents. On 05/18/16 at 3 PM, R2, R6, R18, R25, R26, R27, R28, R29 and R30 said they did not know they can see a copy of the latest facility survey inspection result. None of them knew where the report was kept in the facility and nobody saw a posting of the notice of its availability. On 05/18/16 at 4:18 PM, E4 (Receptionist) stated, "Nobody told me where the survey result is located." The facility's Annual Health Survey and Complaint Report Book dated July 30, 2015 did not include the Complaint result in the book. On 05/18/16 at 4:34 PM, E1 (Administrator) said only the Annual Result/Report is what they are putting in the book.	F 167		
F 223 SS=D	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 interview and record review the facility failed to prevent a male resident (R20) from physical / sexual assault towards a female resident (R19) against her will, unnoticed by staff. R20 engaged in sexually inappropriate action including kissing and groping R19 in her bed. R19 expressed she was in shock when she found	F 223		

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R20 on top of her, in her bed, kissing and groping without her consent. R19 said she was emotionally distraught, felt unsafe and her rights were violated.

This applies to one of three residents (R19) in the sample of 21 residents evaluated for abuse.

The findings include:

R19's 5/14/16 Progress Notes and the incident the facility sent to the Department on 5/14/16 involving R19 and R20 showed the facility received a call from a person from another facility. This person saw a post on Social Media stating R19 on Thursday a peer in the facility came to into her room while she was sleeping and was on top of her kissing and groping her breast without her permission.

The facility investigation completed on 5/19/16 and concluded the allegation of sexual abuse was not substantiated.

On 5/19/16 at 4:46 PM, R19 over the telephone stated the night the incident occurred (5/11/16 night early morning of 5/12/16), she slept poorly, barely had couple hours of sleep. R19 said she was shocked to wake up to see R20 on top of her, hugging, kissing and groping her. R19 said her boyfriend (R35) who usually walks in dining room and halls, saw her room door was opened, R35 came up to her room and noticed R20 in her bed when he opened her privacy curtain, and R20 left her room. R19 said she was shocked, frozen, violated her space and felt very unsafe and did not know what to do. She thought R35 would do something about it, but he left on home visit. R19 said it was hard for her to process the trauma,

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and started to tell her peers about the incident and how upset she was. When one of her peers (R15) told E8 (Counselor), E8 spoke to her, but nothing was done.

On 5/13/16 R19 said after R15 told the counselor (E8), she called speak to her, but she did nothing. R19 then posted the situation on a Social Media account. The facility then sent her to the hospital on 5/14/16. At the hospital she refused to have rape kit done, because there was no penetration and the hospital sent her back to the facility. On May 16, 2016 the facility sent her back to the hospital saying she was having coping problems.
R19 continued to state the night staff sleeps at night, does little to monitor residents. R20 was supposed to stay in his hall (C - Hall) and day area at night. R20 had to pass his hallway, day area and pass several rooms in the hall (A - Hall) to come to her room. If the staff monitored R20, he would not have reached her room. R19 concluded she is still upset about whole incident.
The facility identified R19 to be alert, oriented to time, place and person per her 4/5/16 Minimum Data Set (MDS) with a Brief Interview for Mental Status (BIMS) score of 15 of 15. R19's January 2015 admission record showed she has recurrent depressive disorder with suicidal ideations.
On 5/19/16 R35 volunteered to speak in detail and said he usually walks in the facility between 4:00 am and 6:00 am for his daily exercise. When R35 was walking in halls and day area, he noticed R19's room door was open and walked farther, opened the privacy curtain, found R20 lying on top of R19, his face nuzzled on her neck and R20 left the room when he asked him to leave. R35 said R19 verbalized to him, she was shocked, frustrated and feared for her safety, she

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was upset because he did not do anything about it. R35 had to go on pass with his family that morning. R35 stated he knows who was working (E9, E10, and E11 - Certified Nurse Aides - CNAs) at the time of the incident. The staff was sleeping at the time of the incident. The facility does not do much to protect the residents in the facility.
The facility identified R35 to be alert, oriented to time, place and person per his 4/12/16 MDS with a BIMS score of 15 of 15.
On May 19, 2016 at 4:50 PM interviewed E8 in the staff room. E8 stated she was not told about R20 being in R19's room on May 12, 2016 around 5:00 AM until next day. R15 is the one who told her. E8 said she spoke with R19, but she remained normal. Later the next day when the facility became aware from an another facility staff stating R19 posted the incident on Social Media. E8 said she proceeded to follow the facility protocol for reporting and the Administrator (E1) notified necessary authorities including Local Police Department. E8 said the night shift staff should have watched R20 for his wandering into other residents' room.
On 5/20/16 at 6:00 am interviewed E9, E10 and E11 over the telephone. None of these employees working on 5/11/16 working were aware how R20 entered R19's room unnoticed by them. All three CNAs stated R20 lives in ' C ' hall and not supposed to go to other halls. E10 was assigned to ' C ' hall, but he was busy doing blood glucose checks. E11 was assigned to ' D ' hall, but he was also doing blood glucose checks. E9 was assigned to ' A ' hall, but he also had other assignment in ' E ' hall to get up residents for the morning. E9 also said, usually they have four CNAs, but on the day of the incident there were only three CNAs and they had to cover for

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the fourth. The charge nurse stated she was busy passing medications on the day of the incident, but all staff is responsible for watching the residents and she did not know about the incident until couple days later.
The facility December 2015 Resident Council Minutes showed the residents expressed concerns the night shift CNAs are hard to locate.
The survey team calculated minimum required staffing ratio. On 5/11/16 and 5/12/16 the facility did not meet minimum staff hours. The minimum staff hours was 2.5 hours, where as the provided on 5/11/16 2.04 hours and on 5/12/16 the facility provided 2.06 hours.
R20's June 2012 admission record showed he is a 52 year old and has diagnoses including Schizoaffective disorder and Bipolar disorder.
R20's March 2016 MDS showed he has BIMS score 9 of 15, which meaning he is alert, but has memory impairment. R20's March 2016 Risk for abuse assessment showed he has current / history of social inappropriate behaviors including yelling, screaming, repetitive complaints, making false allegations, wandering, and disrobing in public. The assessment also showed R20 has a history / current behavior of physical or threatening physical aggression towards others.
R20's March 2016 Aggression and Violence History and Screening Assessment showed he has current / history of self destructive statement / behaviors / threats, has diagnosis of severe mental illness, also has recent / history of aggressive / agitated behaviors including destruction of property, physical altercation with others, fire setting, or other violent acts. R20 also has a history of suicidal ideations.
R20's progress notes from November 2015 to May 2016 showed the behaviors including wandering into other rooms (November 19,

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F 223	Continued From page 6 2015); hospitalized from November 20, 2015 to November 24, 2015, for his erratic behaviors and found a knife on him; November 27, 2015 found sharp objects; December 21, 2015 aggressive towards staff during room search; January 17, 2016 called 911 for feelings of unsafe in the facility; February 21, 2016 yelled and screamed at roommate and had to be moved to a different room; March 10, 2016 through May 2016 documented changes in his psychological condition, labile mood, disorganized thinking, rambling speech, hallucinations and delusions. R20's 13 pages care plan initiated in August 2013 included problems including Substance Abuse; unsafe smoking; resisting care; self harm threats; severe mental illness; verbal, physical aggression and inappropriate behavior; abuse and neglect; and other medical problems had no interventions to monitor him from wandering into others rooms. There were no interventions to show he was not allowed to wander into other halls other than where he lives. E1 (Administrator), E2 (Director of Nurses), E6 through E11 (all CNAs) stated R20 is allowed to wander into other halls or other residents rooms only, if someone invites him that too after breakfast hours till bed time.	F 223		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		

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F 278	Continued From page 7 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct an accurate Resident Assessment Instrument (RAI) for R3, R14, R23 and R4 in areas of using mobility device. This applies to four off four residents (R3, R14, R23 and R4) in the sample of 21 residents reviewed for of the accuracy of the Minimum Data Set (MDS). The findings include: On May 18 and May 19, 2016 R 4, R 14, R 22 and R 23 were noted ambulating with walkers. E 3 (Restorative Nurse / Assistant Director of Nursing) stated there were nine residents who ambulate using mobility device / walker and presented the list. This list includes R 3, R 14, R 23 and R 4.	F 278		

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F 278	Continued From page 8 R 3, R 14, R 23 and R 4's most current MDS under mobility devices showed none are used for these four residents. On May 20, 2016 at 10:04 AM, E 3 further explained R 4 came in with it (upon admission / May 12, 2015), R 3 has used walker for over a year now. R 23 was using a walker since March 2016 and R 14 for more than a year. E 3 explained she is in charge in coding the restorative section of the MDS and said she doesn't know why it's coded incorrectly. " This method of coding has a potential for residents not receiving accurate care.	F 278		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct a comprehensive assessment for the residents identified with periods of incontinence, failed to evaluate and identify the type of incontinence and to conduct a voiding pattern in order to implement specific interventions to improve or maintain the current bladder function of the residents.	F 315		

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This applies to two of four residents (R15 and R 5) reviewed for bladder incontinence in the sample of 21 residents.
The findings include:
On May 19, 2016 at 2:00 PM, E 3 (Restorative / Bowel and Bladder Nurse /Assistant Director of Nursing) identified 19 residents are incontinent of urine. E 3 explained there was no one in the facility placed on a formal or retraining program and all of these 19 residents are placed on check and change (check for wetness) only.
On May 20, 2016 at 9:40 AM, R 5 was noted in the dining room sitting in her wheelchair. R 5 said she would like to be more independent. She is in a wheelchair but could transfer herself from my bed to the wheelchair. She said she has hard time doing it and has fallen a lot because of this. She said she has had numerous accidents (incontinent episodes) at night, so started to use pull ups (disposable incontinence brief). The staff knows about it (incontinence episodes). She said, " No there's really no one to help (staff) at night. "
R 5's most current Minimum Data Set (MDS) dated March 17, 2016 showed R 5 has no cognitive problem and with occasional bladder incontinence. E 3 presented R 5's voiding pattern form dated March 8, 9 and March 10, 2016. This voiding pattern of R 5 was not identified. The Care Plan / MDS Coordinator was unable to present an actual incontinence care plan for R 5 instead presented a care plan for potential / actual alteration in skin in which it shows that R 5 has " urge, stress and mixed " bladder incontinence and also documented occasional incontinence with dribbling urine at night ... She (R 5) is fair for retraining) ... makes needs known ...
R 5 was not in a re-training program. R 5's interventions were not specific to R 5's identified

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bladder problem.
On May 19, 2016 at 2:30 PM, E 3 explained R 5's incontinence is related to inability to go to the bathroom (functional incontinence) and she (R 5) can verbalize her needs to go to the bathroom and can clean her self.

On May 19, 2016 at 12:59 PM, E3 (Assistant Director of Nursing / Restorative Program Director) and E5 (Certified Nursing Assistant-CNA) said R15 is incontinent of bladder. E3 said R15 needs prompting / assistance at night. E3 said they chose to work with her during the night only because it is too much for her if they prompt her during the daytime.

R 15's type of incontinence was not identified in R 15's clinical records. On May 19, 2016 at 1:00 PM, E 3 was unable to present any documentation the facility assessed and analyzed R 15's type of incontinence. E3 stated, " I messed up, I did not identify clearly the type of incontinence the resident has. " E3 said (R15) does not want staff to help her.
R15's undated Restorative Nursing Progress notes (printed on May 19, 2016) showed only one episode when R15 refused staff ' s assistance getting out of bed to go to the washroom.
On May 19, 2016 at 11:49 AM, E5 (CNA) stated 4 (four) residents are sharing 1 (one)washroom. E5 stated, " In that case, we just direct them to use the neighbor's bathroom. " E3 said she is not aware R15 has problems using the washroom since other residents are sharing it with her.
On May 19, 2016 at 8:53 AM, R15 said if she

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F 315	Continued From page 11 does not get to the bathroom really quick and when the bathroom is occupied by another resident then she will have periods of incontinence. R15's current MDS (Minimum Data Set) dated March 9, 2016 showed R15 ' s BIMS (Brief Interview for Mental Status) score of 15 (interviewable). The same MDS showed R15 has occasional bladder incontinence. On May 19, 2016 at 2;00 PM, E 3 presented R 15's 3-day Bowel and Bladder Voiding Diary. This form was not dated. There was no analysis. The summary section was blank. R15's care plan did not show an individualized and specific intervention to help address R15's incontinence. The facility's current Bowel and Bladder Assessment policy showed " Based on the resident's comprehensive assessment the facility will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel as possible. Each resident will be assessed for 72 hours for bowel and bladder voiding patterns on admission, quarterly and with a significant change in elimination patterns." The facility did not follow the policy and procedure.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to monitor a male resident (R20) to prevent from getting into bed with a female resident (R19) against her will, unnoticed by staff. R20 engaged in sexually inappropriate action including kissing and groping R19 in her bed.

R19 expressed she was in shock when she found R20 on top of her, in her bed, kissing and groping without her consent. R19 said she was emotionally distraught, felt unsafe and her rights were violated.

This applies to one of three residents (R19) in the sample of 21 residents evaluated for safety of the residents.

The findings include:

On 5/18/16 at 4:00 PM R35 stated he witnessed a male resident who is only supposed to be in ' C ' hall, going into his girlfriend's room last Thursday. The incident was sexually inappropriate in nature, but the staff accused him of lying. R35 said the staff usually sits at the table and plays on phones.

R19's 5/14/16 Progress Notes and the incident the facility sent to the Department on 5/14/16 involving R19 and R20 showed the facility received a call from a person from another facility because the person saw a post on Social Media stating R19 on Thursday a peer in the facility came to into her room while she was sleeping and was on top of her kissing and groping her breast without her permission.

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The facility investigation completed on 5/19/16 and concluded the allegation of sexual abuse was not substantiated.

On 5/19/16 at 4:46 PM R19 over the telephone stated the night the incident occurred (5/11/16 night early morning of 5/12/16), she slept poorly, barely had couple hours of sleep. R19 said she was shocked to wake up to see R20 on top of her, hugging, kissing and groping her. R19 said her boyfriend (R35) who usually walks in dining room and halls, saw her room door was opened, R35 came up to her room and noticed R20 in her bed when he opened her privacy curtain, and R20 left her room. R19 said she was shocked, frozen, violated her space and felt very unsafe and did not know what to do. She thought R35 would do something about it, but he left on home visit. R19 said it was hard for her to process the trauma, and started to tell her peers about the incident and how upset she was. When one of her peers (R15) told E8 (Counselor), E8 spoke to her, but nothing was done.

On 5/13/16 after R15 said she told her counselor (E8). E8 called me to speak to her, but she did nothing. R19 then posted the situation on a Social Media account. The facility then sent her to hospital on 5/14/16. At the hospital she refused to have rape kit done, because there was no penetration and the hospital sent her back to the facility. On May 16, 2016 the facility sent her back to the hospital saying she was having coping problems.
R19 continued to state the night staff sleeps at night and does little to monitor residents. R20 was supposed to stay in his hall (C - Hall) and day area at night. R20 had to pass his hallway,

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day area and pass several rooms in the hall (A - Hall) to come to her room. She said if the staff monitored R20, he would not have reached her room. R19 concluded she is still upset about whole incident.
The facility identified R19 to be alert, oriented to time, place and person per her 4/5/16 Minimum Data Set (MDS) with a Brief Interview for Mental Status (BIMS) score of 15 of 15. R19's January 2015 admission record showed she has recurrent depressive disorder with suicidal ideations.
On 5/19/16 R35 volunteered to speak in detail and said he usually walks in the facility between 4:00 am and 6:00 am for his daily exercise. When R35 was walking in halls and day area, he noticed R19's room door was open and walked farther, opened the privacy curtain, found R20 lying on top of R19, his face nuzzled on her neck and R20 left the room when asked to leave. R35 said R19 verbalized to him, she was shocked, frustrated and feared for her safety. She was upset because he did not do anything about it. R35 had to go on pass with his family that morning. R35 stated he knows who was working (E9, E10, and E11 - Certified Nurse Aides - CNAs) at the time of the incident. The staff was sleeping at the time of the incident. The facility does not do much to protect the residents in the facility.
The facility identified R35 to be alert, oriented to time, place and person per his 4/12/16 MDS with a BIMS score of 15 of 15.
On May 19, 2016 at 4:50 PM interviewed E8 in the staff room. E8 stated she was not told about R20 being in R19's room on May 12, 2016 around 5:00 AM until next day. R15 is the one who told her. E8 said she spoke with R19, but she remained normal. Later the next day when the facility became aware from an another facility

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staff stating R19 posted the incident on Social Media. E8 said she proceeded to follow the facility protocol for reporting and the Administrator (E1) notified necessary authorities including Local Police Department. E8 said the night shift staff should have watched R20 for his wandering into other resident's rooms.

On 5/20/16 at 6:00 am E9, E10 and E11 were interviewed over the telephone. None of these employees working on 5/11/16 were aware how R20 entered R19's room unnoticed by them. All three CNAs stated R20 lives in ' C ' hall and not supposed to go to other halls. E10 was assigned to ' C ' hall, but he was busy doing blood glucose checks. E11 was assigned to ' D ' hall, but he was also doing blood glucose checks. E9 was assigned to ' A ' hall, but he also had other assignment in ' E ' hall to get up residents for the morning. E9 also said, usually they have four CNAs, but on the day of the incident there were only three CNAs and they had to cover for the fourth CNA. The charge nurse stated she is busy passing medications on the day of the incident, but all staff is responsible for watching the residents and she did not know about the incident until couple days later.

The facility December 2015 Resident Council Minutes showed the residents expressed concerns the night shift CNAs are hard to locate.

The survey team calculated minimum required staffing ratio. On 5/11/16 and 5/12/16 the facility did not meet minimum staff hours. The minimum staff hours was 2.5 hours, where as the provided on 5/11/16 2.04 hours and on 5/12/16 the facility provided 2.06 hours.

R20 ' s June 2012 admission record showed he is a 52 year old and has diagnoses including Schizoaffective disorder and Bipolar disorder.

R20 ' s March 2016 MDS showed he has BIMS

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score 9 of 15, which meaning he is alert, but has memory impairment. R20's March 2016 Risk for abuse assessment showed he has current / history of social inappropriate behaviors including yelling, screaming, repetitive complaints, making false allegations, wandering, and disrobing in public. The assessment also showed R20 has a history / current behavior of physical or threatening physical aggression towards other.
R20's March 2016 Aggression and Violence History and Screening Assessment showed he has current / history of self destructive statement / behaviors / threats, has diagnosis of severe mental illness, also has recent / history of aggressive / agitated behaviors including destruction of property, physical altercation with others, fire setting, or other violent acts. R20 also has a history of suicidal ideations.
R20's progress notes from November 2015 to May 2016 showed the behaviors including wandering into other rooms (November 19, 2015); hospitalized from November 20, 2015 to November 24, 2015, for his erratic behaviors and found a knife on him; November 27, 2015 found sharp objects; December 21, 2015 aggressive towards staff during room search; January 17, 2016 called 911 for feelings of unsafe in the facility; February 21, 2016 yelled and screamed at roommate and had to be moved to a different room; March 10, 2016 through May 2016 documented changes in his psychological condition, labile mood, disorganized thinking, rambling speech, hallucinations and delusions.
R20's 13 pages care plan initiated in August 2013 included problems included Substance Abuse; unsafe smoking; resisting care; self harm threats; severe mental illness; verbal, physical aggression and inappropriate behavior; abuse and neglect; and other medical problems had no interventions

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F 323	Continued From page 17 to monitor him from wandering into others rooms. There were no interventions to show he was not allowed to wander into other halls other than where he lives. E1 (Administrator), E2 (Director of Nurses), E6 through E11 (all CNAs) stated R20 is allowed to wander into other halls or other residents rooms only, if someone invites him that too after breakfast hours till bed time.	F 323		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a smoke - free environment for residents and staff who use rooms near the facility designated smoking area. This applies to two residents (R15, R16) in the sample of 21 and four residents (R32, R27, R34 and R36) in the supplemental sample. The findings include: On May 19, 2016 the facility identified 54 residents who smoke in the facility. Residents were using the designated out door smoking area located between the A and B wings of the facility on all days of the survey from May 17 through May 20, 2016. A large amount of smoke could be seen in this area when residents were smoking. There is a fence at the end of the patio to seclude	F 465		

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the smoking area, but is adjacent to the employee break room and two rooms on each hallway. Rooms A2 and A4, B1 and B3 have windows that open to this smoking area. Smoke was observed in these rooms during smoking times. A smoke odor could be detected while in the employees break room.

On May 18, 2016 at 1:15 PM R33 and R16 said they can smell smoke in their room if the window is open. R33 said smoke is not good for her health. On May 18, 2016 at 10: 40 AM R15 said the smoke stinks, R36 said she is not a smoker and gets second hand smoke. On May 18, 2016 at 10:00 AM R32 said the smoke is terrible, its hard to get fresh air in her room. On May 19, 2016 R15 said it is stuffy in the bedroom, there are no fans. I want to open the window but the smoke stinks.

The undated facility smoking policy presented during the survey states, POLICY: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitors. The interior of the facility will remain smoke-free at all times.