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ROCK RIVER GARDENS	3601 SIXTEENTH AVENUE STERLING, IL 61081

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F 000	INITIAL COMMENTS Complaint #1615456/IL #88690 - F157, F224 and F309 cited. Complaint #1615485/IL #88721 - No deficiencies cited.	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 the address and phone number of the resident's legal representative or interested family member.	F 157		

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify a resident ' s legal representative of two falls. This applies to 1 of 3 residents (R1) reviewed for notifications in the sample of 4. The findings include: On September 22, 2016 at 3:30 PM, Z3 (R1 ' s guardian) said she was not notified of a fall or incident on September 17 or 18, 2016. Z3 said she is R1 ' s legal representative for healthcare and is to be notified of any incident, falls and change in condition. R1's nurse ' s note dated September 17, 2016 (7-3) shows R1 said she rolled out of bed. There is no documentation Z3 was notified. The nurse ' s note dated September 18, 2016 (7-3) shows R1 had a fall from a chair and R1's record has no documentation that Z3 was notified. R1 ' s medical record shows a signed plenary guardian certificate dated February 12, 2016 appointing Z3 as her legal guardian. R1 ' s face sheet shows Z3 is the guardian for healthcare as does the September 19, 2016 facility transfer form. The facility's Notification policy dated July 1, 2012 shows the facility shall promptly notify appropriate individuals (Guardian) of changes in the resident condition and/or status.	F 157		
F 224 SS=G	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.	F 224		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility neglected to follow their policies on notification for a change in condition or status, pain prevention, emergency care and treatment and the facility policy on abuse prevention by not assessing a resident and seeking treatment for a resident who reported pain between September 16, 2016 to September 19, 2016. This failure resulted in a delay in treatment and an increased need for assistance with activities of daily living (ADLs). The resident was admitted to a local hospital and was diagnosed with a right hip fracture requiring surgical repair.
This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 7.
The findings include:
R1 ' s initial MDS (minimum data set) of May 15, 2016 shows independence in ambulation and locomotion and R1 has not had any falls or behaviors. The MDS shows she is 51 inches tall and 192 pounds.R1 ' s MDS shows occasional mild pain. The psychiatric evaluation dated July 21, 2016 shows R1 is a 33 year old white female with a history of MR (mental retardation), bipolar disorder, and borderline disorder.
R1 ' s nurse's note dated September 16, 2016 shows R1 yelling that she can't walk, was lying in the hallway and continued to request an ambulance. This note shows R1 crawled to her room. The nurse's notes dated September 18, 2016 (7-3 shift) show R1 fell out of a chair in the TV room after taking her morning medications,

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refused to get up and rolled around (on the floor) until lunch time. R1 ' s nurse's note dated September 18, 2016 (3-11 shift) shows R1 was sitting naked on the shower floor. R1 was walked to her room (almost the whole length of the hallway) with a gait belt and three assistants supporting most of her body weight. R1 told staff, I don't want to be here. E14 RN (Registered Nurse) told her to discuss that with social services, the DON (Director of Nursing) and the Administrator.

On September 22, 2016 at 8:50 AM, E12 and E13 maintenance measured the distance from R1 ' s room (room 20) to the nurse ' s station/TV room and said it was 148 feet one way. The distance from R1's room to the north shower room was measured by E12 and E13 as 120 feet each way.

On September 21, 2016 at 8:45 AM, R5 said R1 was screaming in pain for days because she couldn't walk for a few days before she went to the hospital.

On September 21, 2016 at 9:00 AM, R6 said R1 complained she could not walk and they were trying to get her to. She was on the floor in the hallway (on Saturday, September 17th) and they just put cones around her so nobody would walk on her. R1 was screaming in pain for three days when she was trying to walk and they were trying to get her out of bed. She kept complaining to staff that she hurt and they thought she was faking it, I guess. R1 did not normally scream, yell and make a fuss. She would normally walk the halls. She yelled that she was in pain and could not walk. My room is directly across from hers. R6 said they should have sent her to the hospital. They think she was putting on a show. R1 was standing on her tippy toes to walk and they used gait belt and two people. They continued to walk

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her even though she was in pain.
On September 21, 2016 at 9:50 AM, E5 CNA (certified nursing assistant) said they started using a gait belt and two people to assist with ambulation on Friday (September 16th) because it was the only way to get her up and walk. E5 said normally R1 walked on her own and I attributed her not walking to a behavior.
On September 21, 2016 at 2:25 PM, E7 CNA said (on Friday, September 16th) R1 seemed to be in pain and said she had pain. I notified the nurse (does not recall which one) of her pain and incontinence as this was not normal.
On September 21, 2016 at 1:55 PM, E4 LPN (Licensed Practical Nurse) said on Sunday (September 18th) R1 was still screaming and yelling I can ' t do it .I can ' t do it. I can ' t walk. R1 fell Saturday and Sunday.
On September 22, 2016 at 9:05 AM, E15 PRSC (psychiatric rehabilitation services coordinator) said if a resident complained of pain for days and was forced to walk on a broken limb for days "it would not affect their mental status " . E15 said R1 suddenly became dependent, "like a switch flipped " . E15 said she worked the weekend of September 17-18, 2016. E15 said R1 was complaining of pain and the CNA ' s (certified nursing assistants) and nurses were aware of her complaints.
On September 22, 2016 at 11:35 AM, Z1 (Orthopedic surgeon) said R1 ' s continued ambulation on the fractured leg would cause unnecessary pain, suffering and had to be pure misery.
The facility ' s Pain Prevention and Treatment policy revised January of 2010, defines pain as an unpleasant sensory and emotional experience associated with actual or prtenial tissue damage or described in such terms of such damage. Pain

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is subjective and should be documented as perceived by the resident. Pain management is defined as the assessment of pain and if appropriate, treatment in order to assure the needs of residents who experience problem with pain are met. This document, under procedure number 2 states, Assessment of pain will be completed with changes in the resident ' s condition, self reporting of pain or evidence of behavioral cues indicative of the presence of pain.
The undated facility ' s policy on emergency care states the facility will strive to provide emergency care to the residents as required. Under procedure numbers 3-4, the C.N.A. or Charge nurse is to assess the resident ' s condition and extent of injury or condition and report to the charge nurse immediately. The charge nurse shall attend to the resident ' s need for emergency treatment within his/her scope of capabilities and per facility protocol to stabilize the resident ' s condition.
The facility ' s policy on Notification for change in a resident ' s condition issued July 1, 2012, has as its purpose for the facility and or facility staff shall promptly notify appropriate individuals (i.e. Administrator, DON (director of nursing), Physician, Guardian, HCPOA ,etc) of changes to the medical/mental condition and or status. Under Procedure number one, the nurse supervisor/charge nurse will notify the resident ' s attending physician or on call physician when there has been any symptom , sign or apparent discomfort that is sudden in onset, (is a) marked change in relation to usual signs or symptoms and is unrelieved by measures already prescribed.
The facility ' s abuse prevention program defines neglect as the failure to provide , or willful

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F 224	Continued From page 6 withholding of adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish or mental illness of a resident	F 224		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide nursing services by not assessing and identifying a medical injury for a resident who suffered two known falls on September 17 and 18, 2016. This failure resulted R1 complaining of pain and having an inability to walk due to the pain. This failure also resulted in a delay in treatment, a decline in the resident ' s control of continence of bowel and bladder and an avoidance of weight bearing activities. R1 was sent to a local hospital three days after symptoms began and was diagnosed with a right femoral neck fracture. This applies to 1 of 3 residents (R1) reviewed for pain in the sample of 7. The findings include: R1 ' s initial MDS (minimum data set) of May 15, 2016 shows independence in ambulation and locomotion. R1 has not had any falls or	F 309		

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behaviors. R1 has clear speech and is able to be understood and understands others. R1 self performs all ADLs (activities of daily living) and has no limitations in range of motion. The MDS shows she is 51 inches tall and 192 pounds.R1 ' s MDS shows she is cognitively intact and has occasional mild pain. R1 ' s psychiatric evaluation dated July 21, 2016 shows R1 is a 33 year old white female with a history of MR (mental retardation), bipolar disorder, and borderline disorder.
The nurse ' s notes dated September 15, 2016 show R1 required 2 assistants and a gait belt for transfer, refused to walk to get her medications, non-compliant getting out of bed, was yelling she needed an ambulance as she was unable to walk and this " behavior " started after her home visit was cancelled.
R1 ' s social service progress note shows the facility spoke with R1 ' s father and POA (Power of Attorney) who said R1 ' s claim she cannot walk, is in pain and needs help are behaviors. There is no documentation the facility noted a history of these " behaviors " before this time.
R1 ' s Psychosocial Assessment shows no rejection of care or attention seeking behaviors.
R1 ' s nurse ' s notes dated September 16, 2016 show R1 continues to yell out and say she can ' t walk but was walked to the dining room with two assistants and her gait was unsteady. R1 refused to go to lunch and was observed lying on the floor in the hallway and crawled into her room. This note shows she continues to request an ambulance and staff redirected and encouraged her numerous times.
(On September 22, 2016 at 8:50 AM, E12 and E13 maintenance staff measured the distance from R1's room to the nurse's station (to receive medications)/TV room and said it was 148 feet

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one way. On September 22, 2016 at 9:50 AM, E12 and E13 maintenance staff measured the length of the hallway from R1's room to the north shower and said it was 120 feet one way.)
The September 16, 2016 3-11 shift note shows R1 refused to get out of bed. This note shows staff told her she needs to get up out of bed and CNA ' s (certified nursing assistant) encouraged her several times.
The nurse ' s note dated September 17, 2016 (11-7 shift) shows R1 was yelling down the hallway and was incontinent multiple times throughout the shift.
R1 ' s September 17, 2016 nurse ' s note (7-3 shift) shows R1 was incontinent of bowel and bladder twice that shift and R1 reported she rolled out of bed. This nurse's note shows R1 was then seated in the TV room and yelled the whole time she was there. This note shows R1 fell from the chair in the TV room, refused to get off the floor and rolled around until lunch. R1 refused to eat lunch.
R1 ' s nurse ' s note dated September 18, 2016 (3-11 shift) shows R1 was incontinent and was brought to the medication room being held up by two CNA ' s and a gait belt.
R1 ' s September 18, 2016 7:30 PM nurse ' s note shows R1 was sitting naked on the shower floor and was lifted to a chair by the RN (Registered Nurse) and two CNA ' s. R1 was " told " to lift up her leg to put on her underclothes and was " reluctant " to do as she was told. R1 was then walked to her room almost the whole length of the hall (as documented by the RN) with a gait belt and three staff supporting most of her weight. This note shows R1 said she doesn ' t want to be here and the RN told R1 to discuss that with social services, the DON (Director of Nursing) and the Administrator.

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R1 ' s nurses note dated September 18, 2016 (11-7 shift) shows R1 yelled throughout the shift, refused to ambulate to the bathroom and was incontinent of urine and feces multiple times.
R1 ' s nurse ' s notes dated September 18, 2016 (7-3shift) show R1 received a sponge bath and was assisted by two staff and use of a gait belt to get morning medications.
The September 19, 2016 10:30 AM emergency room note by Z4 (Nurse Practitioner) shows R1 told a staff person she fell on September 18, 2016. This note also shows there was a 3 cm (centimeter) bruise to R1's right groin and bruising to the outer aspect of the right knee. R1 also complained of pain with range of motion to the right hip.
R1 ' s September 19, 2016 10:00AM nurse ' s note shows R1 was sent to a hospital. The facility transfer form for R1 ' s shows the reason for transfer was behaviors: refusing to ambulate, states she cannot walk, screams when staff attempt to ambulate and refusing meals. This transfer form shows the resident ' s symptoms began September 16, 2016 and R1 is usually continent of bowel and bladder and now is lying in bed incontinent.
R1 ' s September 19, 2016 9:00 AM nurse ' s note shows R1 continues to refuse breakfast, to ambulate and be non-compliant. R1 ' s September 19, 2016 2:50 PM, case management progress note from a local hospital shows she was sent the emergency room to be evaluated for refusing to ambulate, states she cannot walk, refuses meals and screams when staff attempt to ambulate. This note shows the LTC (long term care) facility felt she was acting out because her father did not visit and there was a history of a recent fall.
The food and fluid intake sheet for September

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2016 shows R1 refused 10 of 13 meals (that require walking to the dining room) from September 15-19, 2016.
R1 ' s Orthopedic physician consultation dated September 19, 2016, shows R1 was sent to the hospital for evaluation of unwillingness to eat, dehydration, refusing to walk for several days resulting in R1 defecating on herself and having to be cared for in bed. This physician consultation shows R1 had a right displaced femoral neck fracture, and she reported she fell in the shower three days ago. The physician history and physical shows the resident told the facility she had right hip pain but they thought she was depressed because her father did not visit. R1 ' s physical exam on this history and physical showed it was painful to move the right lower extremity.
On September 20, 2016 at 2:50 PM, Z2 (hospital case manager) said there was concern R1 could not walk for three days and nobody realized it was a mechanical injury and not a behavior. R1 was in pain, immobile, had new incontinence and it went untreated.
On September 20, 2016 at 2:00 PM, E11 CNA (certified nursing assistant) said R1 was usually up walking in the hall. E11 said this past weekend she was not up at all. E11 said R1 is a good historian and able to verbalize her needs.
On September 21, 2016 at 9:20 AM, E8, CNA said he did not see R1 walk on her own Friday. E8 said he had to use a gait belt because R1 told him it hurt to walk. E8 said when he returned to work on Monday (September 19, 2016-two days later) R1 was still complaining of pain, still incontinent and still saying she could not walk.
On September 21, 2016 at 9:50 AM, E5 CNA said R1 is able to verbalize her needs and did not normally complain of pain. E5 said Friday

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afternoon (September 16, 2016), R1 started being incontinent. E5 said when we wanted her to walk to get her meds she would complain. I attributed all of this to a behavior.
On September 21, 2016 at 10:05 AM, E6 CNA said she was told in report by the night shift (on September 17, 2016) R1 had been incontinent and refused to get out of bed. This was unusual as she normally walked by herself. We were told to redirect her to do as much for herself as possible and were not made aware of any injury. E6 said beginning on Saturday, R1 required two assistants and a gait belt to walk
On September 21, 2016 at 12:35 PM, R1 was lying supine in her hospital bed. Her speech was clear and she was oriented to person, place and time. R1 had good eye contact and showed no objective signs of pain (had hip surgery the day before). R1 said it made me feel like crap that I was in pain and they made me walk on my leg. I tried to keep walking on it. They said it would make me feel better. I never got good pain relief. They should have called the ambulance sooner. They said it was all a behavior and wouldn't listen to me when I told them it wasn't. It hurt.
On September 21, 2016 at 10:35 AM E9 CNA said R1 started complaining on Friday she could not walk because her leg hurt. E9 said on Saturday R1 walked to the bathroom with moderate assistance and R1 leaned and put weight on E9 to walk. E9 said this was unusual as R1 is usually independent with care and does not require any staff assistance. E9 said R1 ' s incontinence started Saturday or Sunday and R1 looked like she was in pain. E9 said at first R1 walked and complained of pain (it seemed to get worse) then R1 started refusing to get out of bed for meals. E9 said E3 LPN (Licensed Practical Nurse) and E4 LPN knew R1 was complaining of

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pain, could not get out of bed and was incontinent over the weekend.
On September 21, 2016 at 12:35 PM, R1 said it made me feel like crap that I was in pain and they made me walk. I tried to keep walking on it; they said it would make me feel better. I never got good pain relief. They should have called the ambulance sooner. They said it was all a behavior and they wouldn ' t listen when I told them it wasn ' t, it hurt.
On September 21, 2016 at 1:30 PM E3 LPN said she was told that R1 ' s Dad said R1 claims she cannot care for herself when she is upset. I heard on Saturday R1 rolled out of bed. E3 said she would do a physical assessment to rule out medical symptoms of pain versus behavioral symptoms. E3 said R1 usually walks up and down hall unassisted.
R1 ' s behavior tracking from July, August and September 2016 does not identify refusal of care, refusing to ambulate or incontinence as behaviors.
On September 21, 2016 at 1:55 PM, E4 LPN said two weeks ago R1 was up walking by herself and on Friday (11PM-11 AM shift) R1 was a completely different person. On Saturday (September 17, 2016), R1 required two assistants to walk, was yelling and screaming down the halls saying I can ' t walk and bring me my meds. R1 said she did not want to get up so E4 said they sat R1 up in her bed to take her medications. E4 said R1 was incontinent of bowel and bladder and E4 told R1 this was totally inappropriate and unhealthy for her. E4 said she encouraged R1 to get up but R1 was incontinent two more times during the shift. E4 said on Sunday R1 required two CNA ' s to assist her to walk down the hall and R1 was yelling and screaming I can ' t do it, I can ' t walk. E4 said she was told R1 rolled out of

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	14E579	A. BUILDING _____ B. WING _____	C 09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK RIVER GARDENS	3601 SIXTEENTH AVENUE STERLING, IL 61081

(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
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bed on Saturday. On Sunday E4 said she had the CNA ' s put R1 in a chair in the TV room and encouraged her to get up and get her own water. E4 said R1 then fell out of the chair in the TV room on Sunday.
On September 21, 2016 at 2:25 PM, E7 CNA on Friday R1 had refused care, refused to get out of bed, go to meals and get her medication (which required walking). E7 said this was not normal for R1 and she seemed to be having pain. E7 said she had never seen these behaviors prior to Friday and R1 ' s father said these were behaviors.
On September 21, 2016 at 2:45 PM, E10 CNA said R1 is normally very compliant and does not exhibit behaviors. R1 is usually fully independent for care. E10 said R1 did not want to walk beginning on Friday because she was in pain. E10 said on Saturday R1 would not get up to go to the bathroom, take her medications or come to meals. E10 said on Sunday she had lunch because " they made her get up " . E10 said R1 began soiling the bed on Saturday and said R1 didn ' t want to get up because it hurt. E10 said the nurse ' s knew R1 was in pain.
On September 22, 2016 at 8:42 AM, E1 Administrator said R1 had not exhibited behaviors before and R1 put herself on the floor twice over the weekend. E1 said R1 was sent to the hospital on Monday to be evaluated for her " behaviors " . E1 said R1 ' s incontinence; complaints of pain and not getting out of bed were believed to be behavioral.
On September 22, 2016 at 9:05 AM E15 PRSC (psychiatric rehabilitation service coordinator) said if a resident had pain for days and was forced to walk on a broken limb it "would not effect their mental status".
On September 22, 2016 at 11:35 AM, Z1

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(Orthopedic surgeon) said R1 suffered a right displaced femoral neck fracture, a fractured hip. Z1 said R1 told him she fell in the shower three days prior and R1's injury is consistent with this type of fall. Z1 said he would expect a person with this type of injury to exhibit pain, inability to walk, pain with toileting and transfer. Z1 said he would expect a nurse to be able to assess this injury and know something was wrong, in fact , the majority of the time it is a lay person who presents to the emergency room and can identify something as abnormal. Z1 said R1 ' s injury was acute and was several days old based on his surgical findings. Z1 would expect to see limited ROM (range of motion), a shortened extremity, an externally rotated extremity and severe pain with movement with this type of injury and all of these symptoms were present when he examined R1. Z1 said behaviors may have clouded the picture in this case but a physical assessment would have revealed the medical problem. Z1 said making R1 walk on the fractured hip would cause unnecessary pain, suffering and had to be pure misery. This also put R1 at risk for additional falls and could have broken her other hip.

On September 22, 2016 at 12:40 PM, E2 DON (Director of Nursing) said R1 has had no physical behaviors since admission. E2 said on Friday (September 16, 2016) R1 said she couldn ' t walk, was crying but would walk with encouragement. E2 said R1 rolled out of bed on Saturday (September 17, 2016), R1 requested to be sent to the emergency room and her " behaviors " continued i.e.; didn ' t want to get up, eat and became incontinent. E2 said on Sunday R1 was ambulating with the aid of a gait belt and on Monday she was sent to the emergency room because her " behaviors " did not improve. E2 said R1 was alert and oriented to person, place

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F 309	Continued From page 15 and time and able to express her needs. R1 would normally do a lot of walking. E2 said the facility determined R1 was exhibiting behaviors based on what they were told by the family.	F 309		