

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/4/04
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 8/26/04
NAME OF PROVIDER OR SUPPLIER LEWIS MEMORIAL CHRISTIAN VLG			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 WEST WASHINGTON SPRINGFIELD, IL 62702		
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F9999	<p>FINAL OBSERVATIONS</p> <p>Surveyor: 10879</p> <p>300.610a) 300.3240b)</p> <p>The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR.</p> <p>The regulations are not met, as evidenced by the following:</p> <p>Based on interviews, observations and record verification, the facility failed to implement written policies and procedure that prohibit the mistreatment and abuse of residents (R1). On 8/4/04 at approx. 11:30pm, R1 made a sexual allegation. The facility failed to conduct an investigation immediately following the allegation according to their policy and failed to conduct a</p>	F9999			

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F9999	<p>Continued From page 24</p> <p>thorough investigation by including interviews with other residents and family members. The facility failed to follow their policy for notification of family and physician and failed to keep the resident and family informed of the progress of the investigation. The facility failed to ensure that employees receive on-going training on abuse allegations and appropriate interventions if and when they occur.</p> <p>Findings include:</p> <p>1) Review of the clinical record identifies R1 as being a 74 year old female admitted to the facility on 7/28/04 with diagnoses of Congestive heart failure, hypertension, Chronic Obstructive Pulmonary Disease and Cerebral Vascular Accident among others. The nursing assessment indicates that R1 is alert/oriented and requires assistance with all activities of daily living. R1 is verbal and capable of communicating well. R1 was intended to be a short term resident of the facility who was admitted for therapy and strengthening exercises prior to returning home with her husband.</p> <p>According to the nurse notes dated 8/4/04 at 11:30pm, R1 voiced a sexual abuse allegation to a CNA. R1 indicated that the abuse occurred at approx. 10:15pm and alleged a man putting his fingers into her vagina. R1 voiced this allegation to a CNA who entered the room to pass ice water. The CNA responded by calling the LPN (E6) into the room. E6 then phoned E3, the Assistant Director of Nursing (ADON) who came to the facility within a short amount of time. E3 interviewed R1 and did a brief assessment, reassured the resident and left the facility.</p> <p>A) The facility failed to conduct an investigation</p>	F9999		

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F9999	Continued From page 25 according to their policy. According to interviews with E1 (Administrator) and E2 (Director of Nursing) on 8/6/04, the Corporate's "Regulatory Compliance Director (E7) and Corporate Nurse were contacted at approx. 7:15am on 8/5/04 and arrived at the facility early that morning. Interview with E2 on 8/9/04 at approx. 3:15pm indicated that once E7 arrived, E2 stepped out of the investigation. Interview with E1 concurs with this information for him as well. Both Administrator and Director of Nursing understood at that time that E7 would be conducting the investigation for the facility. On 8/10/04, a "Final Report for Illinois Department of Public Health" summary was faxed to the department and provided to the surveyors as the facility's investigation. The surveyors were informed at that time that this was the complete investigation. It included no specifics as to a list of employees interviewed, information gathered thru the interviews and any other pertinent information collected as evidence that a thorough investigation had been conducted. E7 indicated on 8/13/04 at 10:24am, when asked for the full information on the investigation responded that "on advise from counsel, the summary reports including his notes would be considered attorney/client privilege and not available" to the surveyors for review. He added that he would contact the attorney in regards to the matter. On 8/13/04, the surveyor asked E1 and E2 for the facility's investigation and was told that E7 had all the information indicating they were unable to provide any information regarding the investigation. On 8/17/04, at approx. 9:20am after asking for the facility's investigation, the surveyor was advised by E1 that E7 "had taken over this investigation which created problems for the facility and himself as Administrator, in handling the specific investigation of sexual assault". At	F9999			

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F9999	<p>Continued From page 26</p> <p>approx. 10:10am, E7 stated that there had been a major miscommunication between the facility and him regarding who was doing the facility's investigation. E7 indicated that he conducted the corporate investigation but stated that the facility was suppose to conduct their own in addition to his. E7 indicated that the attorney advised him to provide the surveyors all information pertinent to the investigation in light of the fact that the facility did not do their own. Therefore, a written summary of E7's investigation was provided at that time. Interviews with both E1 and E2 confirm that they had very little information regarding the sexual assault allegation due to not being involved in the investigation. Review of the facility's "Policy and Procedure for Resident Abuse" indicates under Investigation #1 - "The administrator and/or his/her designee (Assistant Director of Nursing) will investigate reports of neglect or abuse immediately". The policy was not followed.</p> <p>B) The facility failed to conduct a thorough investigation according to their policy. There is no indication that the investigation included interviews of staff members from all three shifts and interviews with other residents or family members as indicated in the policy. The policy also indicates that the resident's physician will be interviewed. This was also not evident in the narrative nor did the facility offer this information in discussion. In addition, there is no indication that the possibility of the perpetrator being anyone but E12 was investigated as well. Some interviews conducted included a question regarding anyone being in the area that did not belong, but no evidence was available that suggested the facility's investigation included looking at other residents as a possibility.</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>C) The facility failed to notify family representatives and the physician immediately according to their policy. E3 (Assistant Director of Nursing) was at the facility shortly after being notified by E6 on 8/4/04. E3 did not inform the family representative nor the physician until the following morning on 8/5/04 at 7:45am and 7:50am respectively although the facility policy clearly states both will be informed "immediately". Interview with family members (8/9/04 at 1:30pm) and the physician (8/11/04 at 1:20pm) confirm no notification was done until the next morning. Both agreed that they would have preferred being notified per policy immediately following the allegation. R1 exhibited signs of anxiousness and anger and did not sleep well according to direct care staff interviewed. No support staff was offered or informed at the time of the allegation. Notification on the following morning was also confirmed by nurses notes and interviews with E2 (8/9/04 at 3:15pm) and E6 (LPN 11-7 8/4/04). In addition, the facility has failed to keep the family notified of the progress of the investigation as well.</p> <p>D) The facility failed to ensure that employees be provided training through on-going sessions. The policy indicates that staff will be trained in appropriate interventions to deal with catastrophic reactions of residents, how staff are to report their knowledge of allegations, and what constitutes abuse.</p> <p>Interviews conducted with E6, who was the 11-7 LPN present when R1 made the allegations, stated she called the ADON (E3) immediately following the allegation as she "didn't know what to do" and had "never have this happen before". E6 was asked if she informed the family and physician of the allegation and stated "no" adding</p>	F9999			

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F9999	Continued From page 28 that she assumed E3 would do so. E6 indicated that she did not know if the policy directed them to do so but stated she would have notified both had she known E3 did not. E6 also indicated that she wrote a narrative which she turned in but did not include the information in the nurses notes. Interview with E17 on 8/12/04 at approx. 1pm indicated that she had been at the facility for 7 years and had no training or review of the Abuse Protocol. E17 indicated she knew nothing of the allegation made by R1. When asked what she would do if anyone made an abuse allegation, E17 stated she would report the incident to E2 in the morning adding that she would write it up and put it under her door. Asked what she would do if an allegation of sexual assault occurred, stated she would wait until the morning to report it. E17 asked the surveyor if she should call E2 during the night or wait until morning. The surveyor asked what the policy stated and she responded that she wasn't sure. E17 did identify where the policy book was. Facility records indicate that Abuse training was conducted on 2/25/04 by the Regulatory Compliance Director. Two others were presented by the Corporate Nurse on 4/6/08 and 4/8/04. Of these inservices, no one from 11-7 shift's signatures are present on the sign in sheets. Interviews conducted on 6 staff members from 11-7 shift, 2 LPN's (E17 and E6) and 4 CNA's (E5, E10, E16 and E18), indicated they had received no training that they could recall on the Abuse Protocol. In addition, only 2 of 5 CNA's from 3-11 shift had been present at the inservices. E15, E12 and E11 indicated no training had occurred since they could remember. The facility has failed to ensure that on-going training is provided to all staff members caring for residents despite the shift they	F9999		

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F9999	Continued From page 29 work. 300.3100d)2) All exterior doors shall be equipped with a signal that will alert staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. This Regulation is not met. Findings include: Observation throughout the survey of the west exterior fire door indicates that the door is alarmed by a with a Wanderguard security system and is capable of being locked otherwise but is basically unsupervised/unsecured during day and evening hours. The door is located in the middle of the building and is in recess of the hall by approx. 20 ft. There is a nurses station located at opposite ends of the hall that expands the width of the building. The exit door is not within vision of either nurses station nor are there any other offices located within visual range to ensure residents do not exit. Interview with several staff members who work 3-11 shift and 11-7 indicate the door remains open due to staff going out at break time to smoke. One CNA indicated that if the door is locked, staff will prop it open with a towel while they are outside. The door was observed to be unlocked and unsupervised at various times on 7-3 and 3-11 shifts in addition to being unlocked at 12:15am on 8/12/04 by the surveyor.	F9999		

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F9999	Continued From page 30 Interview with E1 indicates that the door is unlocked during the day as staff go in and out of it. He identified it as a high traffic area indicating that the door is used by staff, visitors, and vendors. E1 indicated that it should be locked in the evening and at night. E1 indicated on 8/19/04 that the facility has sought other options in the past two weeks such as a key pad lock, etc to install to ensure that the door is locked and secured at all times. The facility failed to supervise a door alarm during the time that it was disconnected and failed to ensure that it was secured when not supervised.	F9999			