

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

SPRINGFIELD TERRACE

14E847

Facility Name

I.D. Number

525 SOUTH MARTIN LUTHER KING DRIVE, SPRINGFIELD, ILLINOIS 62703

Address

Date of Survey: 07/09/2004

ANNUAL LICENSURE SURVEY

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

- 300.661 a) **The facility shall not KNOWINGLY EMPLOY OR RETAIN ANY INDIVIDUAL IN A POSITION WITH DUTIES INVOLVING DIRECT CARE FOR RESIDENTS if that person HAS BEEN CONVICTED OF COMMITTING OR ATTEMPTING TO COMMIT ONE OR MORE OF THE OFFENSES listed in subsections (a) (1) to (27) of this Section UNLESS THE APPLICANT, EMPLOYEE or employer OBTAINS A WAIVER PURSUANT TO subsections (k) and (m) of this Section. (Section 25 of the Health Care Worker Background Check Act.)**

Based on interview and record review, the facility failed to protect residents from potential abuse by an employee with a past history of abuse to a nursing home resident. The facility continued to employ E13, Licensed Practical Nurse (LPN) after the facility obtained knowledge that she had a finding of abuse from 3/29/02 on the nurse aide registry. E13 worked as an LPN charge nurse on the 10PM-6AM shift from 12/18/03 until the present time. E13 worked approximately two nights per week thus placing all residents at risk for abuse. Additional time is required to monitor the implementation of the policies and procedures to assure this does not reoccur.

The findings include:

- 1) During the health care worker background check, while doing the annual licensure and certification survey on 7/6/04, E13, LPN was noted to have a finding of abuse on the nurse aide registry. This was in the facility's binder that included all employees that were ran through the CNA registry. The printouts were dated 02/10/04 and 06/24/04. The majority of registry checks were dated on 06/24/04. Interviews with E4, Assistant Director of Nursing, and E2, Assistant Administrator stated they were aware of a problem with E13's registry check, but thought it had been cleared resolved with the past Administrator and Director of Nursing (DON). The past Administrator and Director of Nursing are no longer employed at

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14E547

Facility Name

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"A" VIOLATION(S):

- 300.661 a) this nursing home..E4 said she was working as a staff nurse at the time and thought she had heard that
 (Cont.) E13 had brought in a letter that resolved a problem. There was an Administrative Warning letter included with E13's registry check from the Illinois Department of Professional Regulation in the binder which stated "we found that you may have been in violation of the Illinois Nursing and Advanced Practice Act in that you were abusive to a resident in that you kicked the legs of his wheelchair while employed at a nursing home in Springfield, Illinois." E13's employee file only contained her IL-W-4 Employee's Withholding Allowance Certificate, copy of her drivers' license and LPN license and social security card. There was no application in her file listing references or educational and work histories. The Administrator and DON who hired her in December, 2003, are no longer employed by the facility.
- On 07/07/04, the Acting Administrator E1 was asked why most of the CNA registry checks were dated 06/24/04. E1 said she identified a problem with the employee files and implemented a check of all employees through the registry.
- There was no indication that the registry check of 06/24/04 resulted in any action being taken against E13 when it identified that she had a finding of abuse. E13's last day of work was 07/05/04 when she worked 10 PM until 6 AM.

(A)