

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

PRINTED: 08/04/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145900	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2006
NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CR CTR-LEWISTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST SYCAMORE LEWISTOWN, IL 61542		
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F 490	Continued From page 44 E1, Administrator, was notified of the Immediate Jeopardy on 03/15/06 at 8:45 AM. The surveyor confirmed through interviews, observations, and record review, the facility took the following actions to remove the Immediate Jeopardy. 1. The facility administrator reviewed all related rules related to abuse, F223, F224, F225, and F 226 to assure complete understanding of the rule and to assure compliance 03/15/06. 2. Corporate quality assurance nurse re-inserviced the administrator and the director of nursing 03/15/06 regarding the proper reporting and investigation of abuse. 3. The reporting and investigating of any abuse allegation will be shared with the Corporate Nurse by the administrator to assure follow through and compliance. In the absence of the administrator the director of nursing will follow the same protocol. 4. A review of all facility investigations will be done by the corporate nurse beginning 03/16/06 and will continue for the quarter to include April, May, and June to assure follow through by administration. Random reviews will then be done for the period of one year. 5. SSD was in-serviced by the administrator regarding appropriate supervision of employees in her department and will be monitored by the administrator. 6. Social worker consultant will provide an additional four hours of consultation with the SSD monthly for the next three months and will be re-evaluated at that time. Hours will be added as needed on an ongoing basis. 7. A prescreening assessment form was obtained by the social worker consultant to be utilized during the initial prescreening to determine	F 490			

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F 490	Continued From page 45 appropriateness of admission. The prescreening may be done by the administrator, director of nursing, care plan coordinator or social service director and will be reviewed by at least two members of the above team. This form will be placed in the resident's file. This policy was received and implemented 03/16/06. The administrator, director of nursing, care plan coordinator, and social service director were in-serviced on 03/16/06 regarding the policy and the form by the corporate nurse.	F 490			
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.3240a)b)d)e) Section 300.1210 General Reuirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)	F9999			

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F9999	Continued From page 46 b) A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (Section 3-610 of the Act) d) A FACILITY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (Section 3-610 of the Act) e) EMPLOYEE AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON CREDIBLE EVIDENCE, THAT AN EMPLOYEE OF A LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT EMPLOYEE SHALL IMMEDIATELY BE BARRED FROM ANY FURTHER CONTACT WITH RESIDENTS OF THE FACILITY, PENDING THE OUTCOME OF ANY FURTHER INVESTIGATION, PROSECUTION OR DISCIPLINARY ACTION AGAINST THE EMPLOYEE. (Section 3-611 of the Act) Based on record review, observation, and interview, the facility failed to prevent the ongoing sexual relationship between one of one resident (R2) and one facility staff member (E6). The facility failed to follow their Abuse Prohibition Policy by allowing staff to continue to work after two of two allegations of abuse were reported to the Director of Nurses. R2 became upset with increasing anxiety. R2's behavior increased resulting in R2 being sent to the hospital for a	F9999			

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F9999	<p>Continued From page 47</p> <p>psychiatric evaluation.</p> <p>Findings include:</p> <p>Facility admission record states R2 is a thirty-two year old male who was admitted to the facility on 12/21/05. R2 has diagnoses of depression, anxiety, seizure disorder, and schizophrenia. MDS (Minimum Data Set) dated 01/03/06 indicates that R2 has some difficulty making decisions in new situations. R2 is completely independent with all his activities of daily living according to this MDS.</p> <p>On 03/10/06 at 10:50 AM, R2 had a short arm cast on his right arm. According to R2 he broke his arm when he punched the wall, after becoming upset with staff 's refusal to give him more medication. Both of R2's eyes were black and blue, with an approximate 2 inch abrasion over his left eye. R2 stated he had become upset and cut his forehead.</p> <p>R2 provided this additional information during interview on 03/10/06 at 10:50 AM: Within two weeks of his admission to the facility, he and Social Service Assistant (E6) began to be "involved." Involved means they spent a lot of time together laughing and talking. R2 continued that he was intimate with E6 - they had attempted to have sexual intercourse. They did a lot of kissing and hugging. R2 "messed with (E6's) butt and breasts." This activity took place both inside and outside the facility. Some activity occurred when E6 would take him on errands in the facility van or when E6 took him to/from appointments.</p> <p>E4, a second shift CNA (Certified Nurse Aide),</p>	F9999			

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F9999	<p>Continued From page 48</p> <p>stated in an interview on 03/08/06 at 2:50 that R2 told her he had been intimate with E6 (Social Service Assistant). R2 told E4 this information as she was going off duty. E4 could not remember the exact date of her conversation with R2 but recalled it was "toward the end of January." R2 told E4 that E6 told him (R2) that E6 loved him and was going to leave her husband and kids for him. E4 stated R2 told her that R2 and E6 had sex in E6's office. E4 stated that she reported this conversation with R2 to E5, LPN (Licensed Practical Nurse), who was the nurse on duty. E4 stated before leaving the facility E4 called E2, D. O.N. (Director of Nurses), on the telephone and reported the information given to her by R2. E4 stated she was told by E2 that she would speak with E6 in her office.</p> <p>E5, a second shift LPN, was interviewed on 03/08/06 at 3:05 PM. That interview yielded the following information: R2 told E5 and E4 that he and E6 were in love and were supposed to be together. R2 stated that E6 "broke his heart." R2 said that he had "been intimate with someone and (E4 and E5) would know who it was." E5 stated that she and E4 assumed that he meant E6. E5 stated that she felt R2 was being honest and truthful. E5 stated that E6 never voiced any activity going on between herself and R2. However, E5 stated that E6 frequently called the facility in the evening to talk with R2. E6 never called the facility to talk with any other residents. E6 according to E5's statements frequently took R2 with her when E6 would run errands outside of the facility or when E6 would take other residents to dialysis. E5 stated that E4 called E2 and reported all of their information received from R2. E5 stated she thought E2 (D.O.N.) did an</p>	F9999			

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F9999	<p>Continued From page 49</p> <p>investigation into the matter.</p> <p>E4 and E5 could not recall the exact date of the conversation with R2. The facility schedule for January 2006 indicates the last second shift that E4 and E5 worked together was on 01/24/06. There was no indication that E6 was suspended or prevented from providing care to residents of this facility.</p> <p>E16, day shift LPN, stated in interview on 03/10/06 at 12:45 PM, that she could recall no specific dates for any of her information. E16 stated she heard in report from one of the third shift nurses (E24 or E25) that R2 had been sent out of the facility because E6 had told R2 that they were going to have to make their relationship a professional one only. E16 stated that according to R2 he and E6 were having an affair. When asked why she (E16) did not report this to management, E16 stated everyone knew it by the time she was certain it was true. E16 had thought R2 was delusional. E16 stated she could not imagine that any staff member would be involved with a resident. E16 stated she recalled R2 came to her with a phone number and asked her to verify that it was E6's number. E16 stated she told R2 she was not sure but another staff person told R2 it was E6's number. R2 then went to the phone and called someone. A few minutes later E16 stated E6 called the facility. E6 asked E16 if R2 was all right. E16 stated yes and inquired why E6 was asking. E6 stated R2 had called her home four times that morning. E16 stated she could recall no other time when other residents or staff called residents from their home or vice versa. E16 stated she knew E6 was informed by someone at the facility and told to keep her</p>	F9999			

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F9999	<p>Continued From page 50</p> <p>relationship more professional because R2 was getting the wrong idea. E16 assumed this was done by the Director of Nurses, but cannot be sure. E16 stated E6 frequently took R2 out of the facility to his appointments and to those of others.</p> <p>E9, CNA, was interviewed on 03/10/06 at 11:56 AM. E9 stated that she had heard rumors that R2 and E6 "liked each other." E9 had also heard about the phone calls back and forth between R2 and E6. E9 stated "in her mind the administration probably knew about R2 and E6, but cannot be sure of this. E9 stated "with all the rumors it would be hard not to. E9 stated that "maybe 3 times a week E6 and R2 would leave the building together."</p> <p>E10, CNA, was interviewed on 03/10/06 at 12:20 PM. E10 stated that she had heard rumors that R2 told other staff that he and E6 had slept together. E10 stated that E4 told E10 that she had reported it all to E2 (Director of Nurses).</p> <p>E11, CNA, stated when interviewed on 03/10/06 at 12:05 PM that she knew E6 took R2 out of the building when he didn't have appointments. E11 had heard rumors that E6 and R2 were making phone calls to each other.</p> <p>E17, CNA, stated when interviewed on 03/10/06 at 12:22 PM that she had heard E6 and R2 had "a fling, an affair, whatever." E17 stated she heard that E6 called here all the time to talk with R2. E17 stated E6 had called R2 a couple of weeks ago from jail. E17 stated that since all this has happened R2 has had good days and bad days. E17 stated that after E6 was arrested R2 admitted to having sex with E6. E17 feels that in</p>	F9999			

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F9999	Continued From page 51 her opinion the administrative staff knew what was going on between R2 and E6. It would be "hard not know with all the rumors." E18, CNA, stated when interviewed on 03/10/06 at 2:50 PM that rumors were going throughout the facility that R2 and E6 were spending too much time together. E22, SSD (Social Service Director), stated in interview of 03/10/06 at 3:25 PM that she had heard R2 and E6 "were having sexual relations." E19, LPN, stated in an interview on 03/10/06 at 2:59 PM that she knew of one night when E6 called the facility to talk with R2. E19 also recalled one night when E6 came to the facility and stated that she (E6) was going to her office. E6 spoke with R2 at that time. E2, Director of Nurses, was interviewed on 01/27/06 at 11:08 AM and on 03/08/06 at 2:35 PM. During the interview of 03/08/06, E2 denied having any knowledge at all of a relationship between R2 and E6. E2 stated she had conversed with R2 only about it not being a good idea for him to call E6 at home. During the interview on 01/27/06, E2 stated she had talked with R2 about a relationship with E6. E2 stated that R2 stated he had made up stuff about E6 and himself. R2 stated he made up the statement that he and E6 had made love, that E6 was leaving her husband, and was quitting her job so that they could be together. E2 stated that this conversation was on a Wednesday morning. E2 stated she did not report this activity because I didn't think it was abuse because they both were consenting adults. I talked to both of them on 1/	F9999			

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F9999	<p>Continued From page 52</p> <p>25/06, Wednesday AM.</p> <p>Two papers dated 01/25/06 and signed by E2 were provided on 01/27/06 during the survey. The papers were information regarding interviews E2 had with R2 and E6. One paper was documentation of a conversation with E6. It stated that E6 denied that anything ever happened between R2 and E6. E6 stated that she provides R2 support through her psychosocial duties. The paper also states E2 told E6 not to let residents call her home unless it was through the nursing staff. The other paper was documentation of a conversation between E 2 and R2. It contains information from R2 denying anything occurred between R2 and E6. E2 documented that R2 said he was "upset" so he made up things about himself and E6. When asked, E2 could provide no further investigation into the rumors or possible involvement of R2 and E6. E6 was allowed to continue working as an employee of the facility until the local newspaper documents her arrest on 01/28/06.</p> <p>The facility Abuse Prevention Program states under Section IV: Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Section V states: Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents. Abuse Prevention Program states facility Administrator or her designee to be the Abuse Coordinator.</p>	F9999			

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F9999	Continued From page 53 Nurses notes from the record of R2 document R2 's reaction to his involvement with E6 ending. Information includes: "01/28/06 10:30 AM This nurse received news that needed to be told to resident. (Z1) called for anxiety med (medication). N.O. (new order) received." During interview with the nurse who wrote this note (E27) on 03/14/06 at 2:42 PM, E27 stated " the news" she told R2 was that E6 had been arrested for shooting her husband. "01/28/06 at 11:00 AM Resident outside on patio hitting brick wall. Pacing et (and) states, 'I should just kill myself.' Resident given TLC (tender loving care) et 1:1. Res. (resident) continues to be anxious. (Z1, attending physician) paged." 01/28/06 11:30 AM N.O. received. See POS (Physician order Sheet). 12PM Res. OOF (out of facility) via (local ambulance service) 3PM (Z2, hospital nurse) at (local hospital) in Peoria called. Res. To return to facility. 01/29/06 2:30 AM Res. Requests prn (as needed) Tyl (Tylenol) #3 (pain medication) for 'severe HA (headache)' et ativan for anxious state of mind. Res. Wandering facility with 1:1 supervision. No suicide comments or attempts. 01/29/06 5:45 AM Res. Complains of increased anxiety. Wanting to have a "shot." Res. Crying 1 :1 et TLC given. 01/29/06 9 PM Res. Up for smoke break. No agitation/anxiety noted at this time. Res. Repeatedly telling stories of a 'broken heart' but in a calm state of mind. 1:1 at all times to monitor behavior.	F9999			

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F9999	Continued From page 54 02/20/06 5 PM Called to West side per nurse et noted res. Standing @ (at) nurses desk with large wound above left eye with large amount bright red blood noted. Sat res. in chair and applied pressure to wound. Res. alert and oriented and cryingres. finally told writer that he had used a razor blade that he had gotten from the sharps container et self inflicted wound to forehead because 'I'm sick of this (s-t), this depression, I can't take it anymore. It helps my inner pain when I hurt myself on the outside.'Asked wing nurse to call MD et (and) get order for transport due to laceration approx. 7 cm (centimeters) in length needing sutures. 02/20/06 5:10 PM (local rescue squad) at facility as well as (local police department). 02/20/06 5:12 PM Director of Nurses aware of incident, requesting psych (psychiatric) eval (evaluation), called (local hospital) et spoke with (Z3, hospital nurse) giving her report on incident. 02/20/06 5:15 PM Res. departed from facility. 02/21/06 9:30 AM Called father at work and informed of incident with (R2) being admitted to hospital." Other records reviewed in R2 ' s record were: Progress notes written by Z4 (psychiatrist) which state: "02/01/06 Was having an affair and says he was in love with female ... who shot husband one week ago. Pt. (patient) very depressed and expressing suicide ideations. 03/03/06 Fell and hit head. Pain relieved his depression for awhile. Decided to cut self on forehead. Went to (local hospital) but only stayed one day. Still upset about female he loved who killed her husband."	F9999			