PRINTED: 11/14/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. BUILDING ______ B. WING ______	C 10/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKINLEY COURT	500 WEST MCKINLEY AVENUE DECATUR, IL 62526

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F 490	Continued From page 25 3. All resident's primary family members and /or responsible parties have been notified of the importance of reporting suspected abuse or mistreatment. This was done by E10 and E6 on 10/11/07 and 10/12/07. 4. All residents were educated on their right to be free from abuse and mistreatment and the importance of reporting any abuse or mistreatment. This was done on 10/12/07 by E11, Social Service and E12, Activity Assistant. 5. All allegations of abuse uncovered by this State Survey Agency investigation were initially investigated starting 10/12/07. Some were finished and some are still ongoing. All of these allegations were reported to the State Agency, Families, and Physicians. These reports are being investigated by E13, Assistant Director of Nurses. The allegations were reported to the State Agency by the Administrator on 10/12/07.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility	F9999		

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administrator. (Section 3-610 of the
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (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.

These REGULATIONS were not met as evidenced by:

Based on observation, interview, and record review the facility failed to investigate and report to the Department, an allegation of abuse involving E3, Certified Nurses Assistant (CNA). This occurred (against an unknown resident) in April of 2007. E3 continued working in direct contact with residents with four additional subsequent allegations of abuse ocurring. There was an allegation of rough treatment toward R1 that culminated in facial bruising and contusions. There was an allegation of rough treatment against E3 that resulted in a fractured wrist to R5. There were also allegations of verbal abuse toward R6, and and an allegation of verbal and mental abuse toward R8. In addition, facility staff did not report the allegations involving R1 to the

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facility's administrator, the facility did not conduct abuse investigations for the allegationss involving R1 and R5, and the facility did not notify the Department of the allegations involving R1 and R5.

Findings include:

1. A facility document titled, "Request For Payroll Correction" signed by E2, Director of Nurses (DON), and dated for April of 2007, indicated E3 was suspended for an allegation of abuse. The report stated, "...Employee was instructed to clock out until complaint against her was investigated..."

E1, Administrator and Abuse Coordinator, indicated on 10/9/07 at approximately 11:00 AM, that the facility did not have an investigation for the April allegation. E1 stated, "...I cannot find an abuse investigation involving (E3) for April of 2007. We suspended her but I can't remember the reason. I cannot locate the investigation...I don't think we notified IDPH (Illinois Department of Public Health)."

Interview with E2, DON on 10/09/07 at approximately 11:15 AM showed that she also did not remember what E3 was suspended for and did not know of an investigation. E2 stated, "...I don't remember why she (E3) was suspended and I don't know of any investigation..."

2. Current Physician Orders dated 9/16/07 to 10/15/07 demonstrated R1 has diagnoses of Parkinson's Disease and Paralysis. The Minimum Data Set for R1, dated 9/12/07, showed R1 has moderate cognitive impairment but has no indicators of delirium or periodic disordered

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thinking or awareness. The MDS also showed R1 can usually make himself understood. R1 needs extensive assist for bed mobility and total to extensive assist for all Activities of Daily Living (ADL's).

Unusual Occurrence Report dated 9/21/07 showed R1 was found with "...1/4 (inch) red area on forehead (and) bridge of nose..." The same report read, "Witness Statement ... At 8:00 AM, I went to get (R1) up and noticed a red mark on his forehead and on the bridge of his nose. His roommate (R6) said that around 11:00 PM he (R6) was woke up by (R1) hollering..." This statement was signed by E8, CNA.

Z1, son and Health Care Power of Attorney for R1, on 10/05/07 at approximately 2:00 PM indicated his dad had complained about people on nights being rough with him before. Z1 stated, "Dad's complained about people being rough with him on nights. This has happened multiple times in the last six months. I went to the nurses with my concerns..." Z1 also stated his brother and mother found R1 with facial injuries on 9/21/07. Z1 stated, "...my mother and brother noticed bruises on (R1's) face and a knot above the right eye (photo included as exhibit). The facility said it was done on night shift."

Interview with E2, Director of Nurses on 10/12/07 at approximately 1:00 PM indicated that 3rd shift was the usual shift of E3 and that E3 would have taken care of R1 on 9/21/07. Facility payroll records demonstrated E3 clocked in at 21:54 (9:54 PM) on 9/20/07 and clocked out at 06:00 (6:00 AM) on 9/21/07.

E8, CNA, confirmed on 10/10/07 at approximately

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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9:40 AM that Z1 had come to her about someone being rough with his dad on nights. E8 stated, "(Z1) had complained to me that his dad said someone the night before had been rough with him. This happened twice since the end of June, (2007). I reported it to the nurse. If the nurses don't do anything I wouldn't know who to go to (report it to)..."

E1, Administrator, on 10/10/07 at approximately 4:00 PM indicated the facility failed to investigate any of the allegations of rough treatment suffered by R1 and reported by his family. E1 stated, "...we did not investigate any of the allegations of rough treatment of (R1) prior to 9/21/07. I was not aware of these allegations."

3. Observation on tour on 10/05/07 at approximately 9:30 AM showed a resident (R5) with a cast on her right arm. When asked what had happened the resident stated, "...the nurse broke my arm..."

Review of an incident report dated 9/7/07 showed R5 had sustained a wrist injury. The report does not show how R5's wrist was injured or to what extent. The report stated, "...reported initially to (E8)..."

Interview with E8, CNA on 10/10/07 at approximately 9:40 AM indicated she had been told by R5 that someone injured her. E8 stated, "...I said to (R5) 'what happened?' She said the nurse slammed her wrist into the siderail. I said 'are you sure?' She said yes. If I touched her wrist or manipulated it in any way she would pull away in pain. She exhibited signs of pain the rest of that day and when I put her down to bed she would not let me touch her wrist...

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Review of a nurses note dated 9/7/07 indicated someone had injured R5's wrist. The note read, "...Assessment showed bruise approx. (approximately) 2 x 3 cm (centimeters) on top of wrist...res. (resident) unable to make a fist and has limited range of motion (without) pain. Res (resident) questioned about what happened (and) she stated that it happened last noc. (night). That she had her hand on top of the bedrail (and) that the nurse leaned over to either pull her up or turn her (and) smashed her hand between the nurse's body (and) the bedrail..."

Review of a statement signed by E3, CNA, and dated 9/10/07, indicated she had a hold of R5's hand when she (R5) was injured. The statement read, "... (R5) grabbed inside of rails and hit her wrist on the top of it when I was taking her hands from between the bars, She said "ouch". We then pulled her up in bed. the nurse looked at her wrist..."

Interview with E3, CNA, on 10/5/07 at approximately 11:00 AM per telephone, confirmed she had a hold of and was applying force to move R5's hand when her wrist was injured. E3 stated, "...we (E3 CNA and E9 Licensed Practical Nurse, LPN) were going to move her up in bed - she (R5) grabbed the siderail. I had a hold of her hand (right hand) and was trying to push it back through the rails. Her hand hit on the top of the rail and she said, 'ouch.'"

Review of an X-Ray report titled "Patient Report" and dated 9/10/07 stated R5 had suffered a fractured right wrist. The report read, "...There is a distal radial fracture demonstrated..."
Interview with E1, Administrator, on 10/10/07 at

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approximately 4:15 PM confirmed the facility did not investigate the incident involving R5 as an allegation of abuse and did not notify the Department. E1 stated, "...no we did not consider it as an allegation of abuse..."

Interview with R5 on 10/4/07 at approximately 10:30 AM indicated she been treated roughly by E3. R5 stated, "...The nurse (E3) leaned against the rail - my arm was on the rail when she leaned against the rail. She knew my arm was on the rail... She (E3) was rough, she was very rough. She was always mean."

4. R6 on 10/5/07 at approximately 10:35 AM indicated E3 had been rude to him and demonstrated an angry outburst. R6 stated, "...I don't remember exactly when this happened but she (E3) had told me she wasn't there to take care of me. I had asked her to do something while she was in the room. I could tell she was angry, she threw the chair across the room. I reported her..."

5. Interview with R8 on 10/11/07 confirmed a pattern of mistreatment to residents by E3. R8 stated, "...She (E3) woke me up and was hitting me with newspapers. I told a nurse but I don't remember which one. I threw a paper back at her. I was not dreaming about this. My roommate witnessed the event. I told my husband but he didn't pay any attention. This was sometime back, I don't remember when..."

Abuse investigation report dated 10/12/07 demonstrates the facility's investigation of the above matter. The report stated, "R8 reported to staff that she had an incident of abuse involving E3. R8 states that E3 came into her room waking

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her up by throwing paper at her, striking her in the face and making her cry. Per reports from R8's roommate (R7), E3 refused to wipe R8 after using the bedpan. Roommate reports that E3 threw toilet paper at R8 hitting her in the face. The report concludes by stating, "After interviewing staff and residents, it is the belief of this administration that an abusive incident did occur..."

6. Review of "Abuse Prevention Program Facility Policy" identified by E1 as the facility abuse policy, demonstrated the facility failed to implement or follow the policy. The policy states, "...The purpose of this policy is to assure that the facility is doing all that is within it's control to prevent occurrences of mistreatment, neglect or abuse of residents. This will be done by: ...orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect, and abuse; ...identifying occurrences and patterns of potential mistreatment; ...implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and filing accurate and timely investigative reports..." The policy goes on to state, "VI INTERNAL INVESTIGATION OF ALLEGATIONS AND RESPONSE...1. Appointing an Investigator. Once the Administrator or designee determines that there is a reasonable cause for possible mistreatment, the administrator or designee will appoint a person to take charge of the investigation...The appointed investigator will follow the Resident Protection Investigation Procedures, attached to this policy..."

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F9999	Continued From page 33 Review of the Resident Protection Investigation Procedures shows an all inclusive 8 page investigative tool that covers: "...Choosing an Investigation Path...Investigation Procedures...The Interview Process...Final Investigation Report...and Resident Protection Investigation Paths" that includes possible physical, sexual, and verbal or mental abuse. The pathways also address theft and neglect. Interview with E1, Administrator, on 10/10/07 at approximately 4:15 PM confirmed the facility did not use this tool for any of the above stated incidents. The Administrator further confirmed that the protocol should have been used as a guide to a thorough investigation and to be in compliance with the facility's own policy. (A)	F9999		