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	145136	A. BUILDING _____ B. WING _____	03/10/2008

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F 490	Continued From page 88 by: Based on interview and record review the facility is not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of for 1 (R13) of 15 sampled residents. It was determined the facility did not ensure that all alleged violations involving abuse are reported immediately to the Administrator of the facility and policies/procedures of the facility were implemented. Findings include The facility failed to ensure that an allegation of abuse was thoroughly investigated and failed to take steps to prevent further potential abuse while the investigation was being done for 1 (R13) of 13 residents on sample. The Director of Nurses was informed that E11, Licensed Practical Nurse, caused R13 to fall from his wheelchair onto the floor by pulling him by the legs, was yelling at R13, and was trying to make R13 go to bed because she was aggravated at R13. The Director of Nurses was notified by staff and failed to remove E11 from patient care to prevent further potential abuse. The Director of Nurses failed to investigate the abuse incident and to inform the Administrator of the allegation and failed to report the incident to the Department.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a) 300.3240b)	F9999		

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F9999	Continued From page 89 300.3240d) 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 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) These requirements are not met as evidenced by:	F9999		

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F9999	Continued From page 90 Based on interview and record review it was determined the facility failed to ensure that one (R13) of 13 residents on the sample was not physically, mentally, and verbally abused by staff (E11). E11, Licensed Practical Nurse, was attempting to discipline R13 for behaviors by yelling at him, and pulling on his legs which caused him to fall from his wheelchair onto the floor and become extremely upset and agitated. E11 also failed to assess R13 for injuries after the fall. In addition, the Director of Nurses failed to follow the facility policies and procedures for abuse after staff who witnessed the abuse notified her: 1) The facility did not ensure that all alleged allegations involving abuse are reported immediately to the Administrator of the facility, and the Department. 2) The facility failed to implement written Policies and Procedures that prohibit abuse of residents, failed to implement their abuse prohibition policy by prompt investigation of an allegation of abuse, failed to follow their Policy and Procedure to remove staff accused of abuse from resident contact pending the investigation to prevent further potential abuse, and failed to have an ongoing abuse training program in place. Findings include: 1. During an interview of E13, Certified Nurse Aide (CNA), on 03/06/08 at 2:45p.m., she stated about one to one and a half weeks ago R13 was in his wheelchair and blocking other residents from going down the hall. She moved R13 out of the way but he continued with the same behavior. E11, Licensed Practical Nurse (LPN), was very	F9999		

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F9999	Continued From page 91 upset with R13 and told E12, CNA ,and E13, CNA, to put him to bed. E9, CNA, was also present. E12 told E11 she would put R13 to bed after she had her break which was just after the residents' supper time. E11 stated, "No he needs to go to bed now." E11 then pulled his (R13's) feet up off the floor and pulled him out of the wheelchair onto the floor. E11 did not assess R13 when she "pulled him to the floor." E13 stated she and a cook helped R13 up and another CNA pushed his wheelchair underneath him and he was taken to his room. E13 went outside and when she came back inside she asked E11 if she was going to make out an incident report and E11 stated, "No because there was no incident, he was lowered to the floor." E9 telephoned E14, CNA, who was not working that night and had been an aide at the facility for four years. E14 told E9 that E2, Director of Nurses (DON), should be called and the incident reported and if "we" (E9, E12, E13) did not report it she (E14) would. E13 stated they did not want to call E2 as she would come to the facility and then E11 "would ride us all night," so they had E14 call. E13 added, "When (E11) pulled R13 to the floor she made no comment. (E11) was mad at (R13)." 2. During an interview of E14, CNA, on 03/06/08 at 3:50p.m., she stated it was a Sunday when E9 called her and stated something happened and wanted to know what he should do. R13 was a little rambunctious after supper, E11 picked up his feet and he slid out of the wheelchair. E11 was yelling at R13 as she was angry. E14 told E9 to call E2 or she would. E13 and E12 wanted E14 to call E2. E14 stated she called E2 and informed her of what E9 had told her. E14 stated E2 told her to call E9 back and tell whoever saw the	F9999		

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incident to write a report and put it under the door to her office and she would review them the next morning. E14 stated E12 and E13 wrote statements and E14 put them under E2's office door that night. E14 stated E18 (Cook) did not want to write a statement as he did not want to get involved. E14 stated E11 called her at home screaming at her to stay out of her business. E14 stated the incident with R13 was on the last Sunday in February (24th). E14 stated E11 LPN is nice one minute and can be "rip roaring" the next. E14 stated she had thought E2 would have come to the facility on 2-24-08 and send E11 home and start an investigation, but E2 did not and E11 has continued to work with no investigation of the abuse.

3. During an interview of E9, CNA, on 03/06/08 at 4:45p.m., E9 stated that he (R13) gets confused and a little agitated--(sundowners) after supper. E12 and E13 asked E9 to assist in getting R13 up off the floor. E9 stated E12 and E13 said E11 pulled R13 out of his wheelchair onto the floor. E11 asked E9 to put R13 to bed after he was picked up off the floor but R13 was too upset. E9 stated he refused to put R13 to bed until R13 calmed down. E9 stated he called E14 and she told him to call E2. E9 stated no one had talked to him about the incident until this interview. E9 stated R13 was a World War II veteran and E9 stated it really upset him that R13 was treated that way.

4. During an interview of E2, Director of Nurses, on 03/06/08 at 9:00a.m., she stated E11 was an evening nurse and R13 did not like her. E2 stated she was not aware of any incident between E11 and R13 and there were no incident form/s completed referencing any incident. E2 stated

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F9999	Continued From page 93 E11 makes out an incident report for everything. During an interview of E2 on 03/06/08 at 4:30p.m., she continued to deny any knowledge of an abusive incident even when she had detailed written statements from staff that an incident had occurred. E2 did state she had a passing conversation about the incident, last week, with E1, Administrator. She stated she had been meaning to talk to E11 about the incident, but E11 had been avoiding her. On 3-6-08 during Daily Status Meeting, E2 confirmed she did not do an investigation. E2 stated the reports were vague and that E11 refused to talk to her. 5. A review of E12's written statement, provided by E2 (this statement was put under E2's door by E14, per E2's telephone instructions), dated 2/24/08, showed R13 was confused, was surrounded by residents and was being aggressive and backing into residents and yelling at them. E11 walked over to R13 and started yelling at him to calm down. E12 pushed R13 away from the other residents. E11 was insisting R13 go to bed. E11 kept insisting R13 go to bed right then so as E12 was pushing him E11 picked up R13's feet. E12 told E11 two or three times to hold on and calm down, told her to hold on so R13 would not slide out of his wheelchair because E11 should have not been dragging his feet. R13 slipped out of his wheelchair but he was not completely out of it yet. E12 tried to tell E11 to put R13's feet down on the ground so that we could lift him back into the wheelchair. E11 tried to lift R13 by his legs and R13 fell the rest of the way onto the floor. E13, E15, and E18 helped R13 back into the chair, the whole time E11 was yelling and causing a scene.	F9999		

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F9999	Continued From page 94 6. During an interview of R13, on 03/07/08 at 1:30p.m., he stated he does not ever remember having a fall, does not know if he has any problems with staff and does not know staff names. When ask if he had any difficulties with E11 he stated "who" he did not know her. 7. During interview of E1, Administrator, on 03/06/08 at 9:20a.m., E1 stated he was not aware of any incident of abuse of R13. E1 stated on 03/06/08 at 4:30p.m. he was not aware of any abuse of R13 until the surveyor brought it to his attention. E1 stated he began an investigation into the incident as soon as he became aware of the allegation. E1 stated E11 LPN has been suspended as of today (03/06/08). 8. During interview of E11, Licensed Practical Nurse, by telephone on 03/07/08, she stated she had no problems/incidents with R13. E11 stated R13 has not fallen in a long time. She again stated she never had any problems with R13. 9. Review of R13's admission record showed he is an 85 year old male admitted to the facility 02/24/07. Review of the physicians orders showed diagnoses, in-part, of Severe Osteoarthritis of the Right Hip, Coronary Artery Disease, Alzheimer's Dementia, Hypertension, Pagets Disease of Bone, Cerebrovascular Accident with Right Sided Weakness, and Post Traumatic Stress. Review of the 01/30/08 Minimum Data Set showed documentation R13 has a short term memory deficit, has socially inappropriate/disruptive behavior four to six days a week which is not easily altered, needs limited assistance of one for transfers, extensive assistance of two for ambulation, has partial loss of range of motion on one side, and has an	F9999		

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unsteady gait, and has impaired decision making. Review of the nurses notes showed no documentation of R13 being on the floor on 02/24/08.

Review of R13's 01/25/08 care plan showed R13 is easily agitated when redirected from people when in his chair, verbal when he is redirected; has poor safety awareness of others and will push past people with his wheelchair running into people with his chair when passing them; and has anxious concerns about others.

Review of the behavior tracking for February and March 2008 showed R13 is easily verbally agitated when redirected away from other people and is to be allowed time to express himself, placed in a less congested area, and staff are to offer to move resident reminding him to ask for help. Review of the behavior tracking showed only one instance of this behavior in February, and no March documentation. Review of the behavior tracking for his poor safety awareness, pushing past people and running into them with his wheelchair, showed R13 is to be escorted through congested areas, remind him to ask for help, place him where he can get out during an activity, and escort to activities and place him where he can be monitored. There is no approach for any behavior that he must go to bed.

10. In an interview on 3/6/08 at 3:30PM, E16, LPN, stated he was working the night of the incident and staff did not report any of the events to him. He stated he found out about it a few days later from the "rumor mill" in the facility.

11. Review of the staffing schedules for

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F9999	Continued From page 96 February and March 2008 showed E11 worked 02/24/08 (night of the incident) and then worked seven more shifts before being suspended until the facility's investigation of the abuse allegation was completed. It was also confirmed that E16, LPN, worked that shift. 12. Record review of the facility Policy and Procedure of January 2008, titled ABUSE, PREVENTION AND PROHIBITION states, "Facility staff shall be trained on the abuse prohibition program during orientation and ongoing during educational sessions... This training program discusses the internal and external stressors related to care giving in long-term care. The training program also identifies Employee risk factors, Facility risk factors, and Residents risk factors. Included in the training program is pre/post testing for competency. Additional In-services shall include: Appropriate interventions to deal with aggressive and or catastrophic reactions of residents...that can be characterized by weeping, blushing, anger, agitation or stubbornness. How staff should report their knowledge related to allegations without fear of reprisal. How to recognize and address signs of burnout, frustration and stress that may lead to abuse... " Interview with E9, E13 and E14, CNA's, on 03/06/08 reflected they had not had an inservice on abuse prevention for a long time. Record review shows facility did do an inservice on 08/17/07 that reviewed facility Policy and Procedure. The inservice did not address abuse prevention, risk factors or assessment of staff understanding. Interview with E20, Corporate Nurse, on 03/7/08 confirmed there was no inservice in the last year on abuse training. E20	F9999		

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F9999	Continued From page 97 stated she would be doing an inservice "today." Policy states, "Resident abuse must be reported immediately to the Director of Nursing and Administrator. The facility Administrator and/or Director of Nursing will thoroughly investigate alleged violations of individual rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse. If a person is identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress...A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician of any injuries noted...Complete a through investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questioner and statements if indicated that will be attached to the Abuse Investigation Format. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift all staff for the identified shift only will complete a questioner and complete a statement if indicated..." Policy states, "When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution or disciplinary action against the employee...The facility employee or agent who becomes aware of abuse or neglect, including injuries of unknown source or alleged	F9999		