STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145449	A. BUILDING ____ B. WING ____	04/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS KNIGHTS TEMPLAR HA	450 FULTON STREET P O BOX 49 PAXTON, IL 60957

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F 520	Continued From page 64	F 520		

5. Based on observation, interview, and record review the facility failed to administer medications as ordered. The facility had 45 opportunities with 5 errors resulting in a 11.11% medication error rate (R17, R22, R7, and R23). No evidence was provided that the Quality Assurance Committee made a good faith attempt to address medication administration errors from the nursing staff.

6. Based on record review and interview, the facility failed to provide proof that each resident or the resident's legal representation received education regarding the benefits and potential side effects of the Influenza and Pneumonia immunization prior to offering the immunization for 15 of 15 sampled resident (R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R14, R15, R16, R17, and 18). No evidence was provided that the Quality Assurance Committee made a good faith attempt to address the immunizations guidelines set forth in the State Operations Manual.

7. Based on observation and record review, staff failed to wash hands using the correct technique to prevent cross contamination for three observations involving three employees for two different residents (R22) and (R3). No evidence was provided that the Quality Assurance Committee made a good faith attempt to address infection control issuses.

8. Based on observation, record review and interview, Administrative staff failed to follow assigned job duties as outlined in Job Descriptions, i.e. Supervising department managers to ensure compliance with regulatory systems, Submitting reports to Illinois Department of Public Health, Training of Nursing

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F 520	Continued From page 65 Staff, Planning of in service education, Investigating all accident/ incidents. No evidence was provided that the Quality Assurance Committee made a good faith attempt to address administrative issues.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.510e) 300.1210a) 300.3240b) 300.3240e) Section 300.510 Administrator e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 300.1210 General Requirements 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 psychological 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. Restorative measures shall include at a minimum the following procedures: Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes	F9999		

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	145449	A. BUILDING ____ B. WING ____	04/14/2008

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ILLINOIS KNIGHTS TEMPLAR HA	450 FULTON STREET P O BOX 49 PAXTON, IL 60957

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F9999	Continued From page 66	F9999		

aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.
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 Requirements are not met as evidenced by:

Based on record review, observation, and interviews, the facility failed to thoroughly investigate and failed to recognize an abusive situation involving R4 (One of 15 sampled residents). Administration failed to immediately initiate an investigation after receiving an allegation of inappropriate behavior by a staff member towards R4. The facility failed to protect residents by allowing the alleged perpetrator to continue working in direct resident contact which placed residents at risk for repeated abuse. A second abusive situation occurred involving the same staff member and another resident (R13).

Findings Include:

1. R4's Physician's Order Sheet (POS) of March 2008, shows diagnoses which includes Dementia, Glaucoma, and Macular Degeneration. R4's history and physical, dated 09-17-07, shows a history of confusion and memory deficits. R4's Resident Assessment Instruments, dated 04-29-07 and 07-23-07, both

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F9999	Continued From page 67 indicate that R4 has highly impaired vision and is dependent on staff for care. R4 was obsserved on 03-25-08, at 1:10p.m., being transferred from her wheelchair into the bed by two Certified Nurse Aides (CNAs) using a gait belt. R4 was given pericare and positioned on her right side with a folded blanket between her knees. On 03-26-08, at 12:08p.m., R4 was observed in the dining room sitting in her wheelchair. Staff was attempting to awaken R4 in order to feed her. During interview, on 03-27-08, at 1:40p.m., with E16, Certified Nurse Aide (CNA), she stated, "I was working the night shift on 09-09-07. The incident occurred between 10:00p.m. and 12:00 midnight. I entered (R4's) room. (E14 and E17, CNAs) were talking. (E14) was bouncing/hitting his knee against (R4's) foot board. (R4) was sleeping. (E16 demonstrated E14's movements using the back of a chair as the foot board of the bed. She bent her knee and as her foot raised off the floor, her knee hit the back of the chair. She repeated this movement several times to demonstrate E14's behavior.) (R17, R4's roommate) was sitting in her wheelchair and told (E14) to 'stop it, you're going to wake (R4) up.' (E17, CNA) and I, also, told (E14) to stop. (E14, CNA) didn't stop. I raised my hand to his shoulder to get him away from there. (E14) said, 'If you ever touch me, I'll hurt you.' (E14) was mad. He was still bouncing at the bed and stopped after he said that. He left the room. Around midnight, (E14) called from the breakroom to tell (E13, Registered Nurse) (RN) that he was leaving because he didn't want to hurt anyone. That he couldn't control himself and he didn't want to be here. When you leave duty	F9999		

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	145449	A. BUILDING ____ B. WING ____	04/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 68 without permission, I think that is emergency. We usually have 3 CNAs and 1 Nurse at night. In my mind he is not ok. I think his mind was unstable." During interview, on 03-27-08, at 10:40a.m., with E17, CNA, she stated, "I told (E13, RN) what was going on and then, (E14 and E16) came out of the room. (E14) was heated. He was told to cool off. (E13) wrote a note to someone and then, the next day, (E1, Administrator, (Adm.), talked to us about this. (E14) was like a kid. He always picked at (R17) with types of "looks" and (R17) would ask him to stop. (E14) was tapping at (R4's) foot board on the bed to get at (R17). It wasn't right. (R4) wakes up easily. (E14) is an immature, snotty nose kid who needs some upbringing/parenting." During interview, on 03-27-08, at 2:50p.m., with E13, RN, she stated, "I recall I was in charge (09-09-07). (E14) went past the desk and said he wanted to go on break. I heard in his voice that he was angry. He was upset. He went to the breakroom and (E16 and E17) came and said he had jarred (R4's) bed, tapping. They said they asked him to stop. He was rude and loud. I am not sure of the time this took place, maybe after midnight. (E14) called me from the breakroom and said he wanted to leave. I advised him not to leave and told him that was a bad idea. He called me a second time on his cell phone, from his car that he was too angry to come back to work. I called (E2, Director of Nurse's (DON), and said that (E14) wanted to leave and that we were down to 2 CNAs. We were left in a lurch that night. (E2, DON), wrote down on paper what took place. I don't have a copy." At this time, E13 became very confused about when she	F9999		

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	145449	A. BUILDING ____ B. WING ____	04/14/2008

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ILLINOIS KNIGHTS TEMPLAR HA	450 FULTON STREET P O BOX 49 PAXTON, IL 60957

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F9999		F9999		

Continued From page 69
called E2 and was unsure if anything was written down.

During interview, on 03-27-08, at 3:25p.m., with E2, DON, regarding the 09-09-07 incident, she stated, "I was contacted by (E13, RN). But I cannot tell you what time of day it was. I don't remember. I can't remember that far back." These comments were in answer to, 1. Who contacted you on 09-09-07? 2. Any documentation of the incident?

During Entrance Communication, on 03-25-08, approximately 10:00a.m., E1, Administrator, was identified as the facility's Abuse Coordinator, responsible for conducting the abuse allegation investigations.

During interview, on 03-27-08, at 9:30a.m., with E1, Administrator, she stated, "I didn't consider 09-09-07 incident as abuse. It was a conflict between 2 CNAs (weren't identified). I reviewed the abuse policy with (E14). The investigation is in his file. It was within my discretion to terminate or not for abandonment. The incident was reported to me from the Nurse. He abandoned his shift. I looked at the big picture and made a decision not to terminate him. He was immature and not experienced. He had worked at (another facility)." During a second interview with E1, on 03-27-08, at 3:15p.m., she stated, "(E14's) action was not intentional. I didn't feel that it was abuse. I felt it was extremely inappropriate and immature."

During interview, on 03-31-08, at 9:30a.m., with E1, Administrator, she presented a diagram of R4's room and placement of staff on 09-09-07. E1 stated, "Abuse is willfulness. (E14) had a

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F9999	Continued From page 70 nervous issue with his knee/leg. (R4) didn't wake up." During interview, on 03-27-08, at 10:00a.m., with R17, (R4's roommate at the time of the 09-09-07 incident), R17 stated, "I don't remember that incident happening. It was a long time ago. I have had some brain damage." Documents found in E14's personnel file: 1. document entitled, "STANDARDS OF EMPLOYEE CONDUCT." Hand written, on the page next to the statement, "fighting or engaging in threatening or intimidating activities," "(E14) has had several confrontations with co-workers and residents." 2. document entitled, "CONDUCT OF EMPLOYEES, CODE OF ETHICS'. 2 hand written notes, "(E14) told a resident he was a female named Joann." "13 residents requested (E14) not to provide care to them." Both notes were initialed by E1, Adm. The document was signed by E14 and dated 09-10-07, indicating he had read and understood the information. 3. E14's performance evaluation, dated 09-07-07, shows a comment, "Remember to use respectful addresses with residents like Sir or Mr. rather than 'Dude.'" 4. E16 and E17's statements about 09-09-07 involving E14, R4, and R17. 5. document entitled, "SECOND WRITTEN WARNING", dated 09-09-07, states, "Uncooperative behavior or acts that are in disregard of established personnel policies or procedures. In addition, left shift before completed defined as abandonment without authorization of a direct supervisor." These five documents are the extent of the investigation E1 stated that was in E14's personnel file.	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 71 E14's September 2007 time card shows that he clocked in on 09-07-07, at 9:59p.m. and out on 09-08-07, at 2:45a.m. (4 hours and 45 minutes worked). According to the staff interviews, the incident took place between 10:00p.m. and 12:00a.m. E14's October 2007 time card shows that his last day worked as 10-18-07. 2. According to an investigation into alleged resident verbal abuse, dated 10-18-07, E14 was involved in a second abusive situation. R13 was the subject of this investigation. In a hand written statement, dated 10-18-07, E15, CNA alleged that E14, CNA, told R13, while preparing to transfer R13 with the mechanical lift, "if you keep that up I'll roll you onto the floor." Prior to E14's comment, R13 had said, "it feels like he's breaking my arm." R13's October 2007 POS shows a diagnoses that includes Dementia, Cataract, Paralysis Agitans, Cerebral Vascular Accident, Coronary Bypass, and Diabetes. Additional diagnoses were noted on R13's Discharge Summary, dated 01-26-07. These included Carpal Tunnel Syndrome, and Parkinson's Disease. R13's RAI dated 09-04-07, shows that R13 was totally dependent on staff for care, receiving Hospice care, had limited range of motion in his neck, arms, hands, legs and feet, and was transferred using a mechanical lift. R13 was not available for observation, as he had expired on 03-11-08. During interview, on 03-26-08, at 10:15a.m., with E15, CNA, she stated, "I walked into (R13's) room. (E14) was working with (R13). I went to help (E14). (E14) was being rude. (R13)	F9999		

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F9999	Continued From page 72	F9999		

appeared uncomfortable. (E14) told (R13) to 'shut up or I'll roll you on the ground.' I talked to (E14) but, I did not report it. I am a brand new CNA."

During interview,on 03-27-08, at 3:15 p.m., with E1, Administrator, E1 stated, "I didn't know about the 13 people that had requested (E14) not take care of them until we were investigating the allegation of verbal abuse (10-17-07)."

E1 presented surveyor with the names of the residents that had requested E14 not take care of them (15). They were R14, 17, 25, 26, 27, 28,29, 20, 11, 21, 30, 15, 31, 32, 16. E23, Admissions personnel, identified 4 out of the 15 residents as interviewable and credible (R14, 21, 15, 16).

During interview, on 03-28-08, at 9:00a.m., with R14, she stated, "(E14) was terribly bossy. (E14) was rough. (E14) rolled me to check my incontinent brief and didn't take his time. (E14) hurried and caused my extremity to hurt. (E14) hurt my right hip and leg. I asked not to have (E14) take care of me. I just didn't want him to take care of me anymore. (E14) had a bad attitude due to being in a hurry! (E14) didn't want to take the time to take care of me. (E14) was unfriendly."

During interview, on 03-27-08, at 1:20p.m., with R15, she stated, "(E14) was too free with the lotion after toileting and getting me ready for bed. He was touching me all over my body. Down in my diaper, periarea, and my breasts. I had a problem with him doing that. I told (E1) about it. That was within the last year."

During interview, on 04-01-08, at 1:35p.m., with