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

NORTH ADAMS HOME	0020925
Facility Name	I.D. Number
2259 EAST 1100TH STREET, MENDON, ILLINOIS 62351	
Address, City, State, Zip	
22344	MAY 8, 2008
Reviewed By	Date of Survey
ANNUAL	02605, 13886, 16341, 25541
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

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):

300.3240b)f) **Section 300.3240 Abuse and Neglect**

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)

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These Regulations were not met as evidenced by:

Based on observation, record review, and interview, the facility failed to keep residents free from verbal abuse, failed to identify behaviors as abuse, failed to follow its own policies to protect residents from further abuse, and failed to prevent further abuse by not implementing interventions to address the behaviors, for 1 of 13 resident with behaviors (R22).

Findings include:

NORTH ADAMS HOME | 0020925
Facility Name | I.D. Number

CONT.

Physician Order Sheet (POS) dated 4/16/08 shows R21 is a 77 year old admitted on 7/27/07. R21's Minimum Data Set (MDS) dated 2/14/08 shows no memory deficit, independence in decision making skills, and no mood or behavior concerns. This MDS states R21 is 61 inches tall. R21 is able to independently propel her wheelchair around the facility.

On 4/24/08 at 12:10 p.m. while surveyor was making survey observations, R21 stated, "I have a problem. (R22) yells at me and calls me names." R21 indicates this was reported to E3 (Director of Nursing/D.O.N.) and E4 (Assistant Director of Nursing/A.D.O.N.). When asked what was done R21 states, "Nothing." R21 stated last time R21 was yelled at by R22 was, "Just this week."

On 4/24/08 at 1:30 p.m., R21 was in the chapel with several residents watching a movie. On 4/24/08 at 3:55 p.m., R21 was in the Activity Room talking with other residents preparing to participate in a craft activity. R21 independently propelled her wheelchair to the chapel for an interview.

On 4/24/08 at 4:00 p.m. R21 stated, "I came here July 28th of last year. (R22) was good then but in January and February of this year he started calling me all kinds of names. The first time I was just coming out of my room and (R22) just started cussing me. He was coming out of his room too. Last Monday when I came back from (a local store) (R22) was there by the nurses' station and he (R22) started calling me names. (The nurses) pushed him (R22) back to his room." When asked what R22 said to her R21 stated, "You don't want me to repeat what he said. It wasn't nice. (E23 Dietary Aide) in the kitchen knows how (R22) treats me. One time I cried." When asked if R21 was scared she stated, "Yes, because (R22) said I'll slap you. You son-of-a-b----. I always keep my door shut. I don't go out at meals until I know (R22's) ahead of me. I live right across the hall from (R22)." When asked if the hallway was the only area where this behavior happened R21 stated, "In the dining room he cursed me and carried on. They pushed him back in the room and told him to behave himself." When asked if other residents were present R21 states, "Oh yeah. Once I was visiting with (R23) and (R22) came down and called me all he (R22) could think of. (R22) came on in the room. The staff came and got him out of the room and put him to bed. The CNA (Certified Nursing Assistant/E13) told me to stay there until she came back. I talked to (E3/D.O.N.)and (E4/A.D.O.N.). My brother talked to (E4). The last time it happened was one day this week. I won't go out of my room if I know (R22) is around." When asked how R21 thought the other residents felt about it R21 stated, "Some of them don't like it. I think they feel sorry for me. (R22) cusses the nurses and the helpers in front of us residents. If I move, I have to pay to move my phone. That's thirty dollars I don't have. I think he (R22) should be the one to move. I said something about it to them and they said they didn't have a room for him."

CONT.

R21's Care Plan dated 2/14/08 contains no interventions to be used regarding interaction with R22. R21's Nurses Notes in current record are from 7/29/07 through 4/02/08 and no entries are documented regarding interactions between R21 and R22.

A Physician order Sheet (POS) dated 4/16/08 states R22 is a 59 year old admitted on 12/28/06. A history and physical dated 3/26/08 states R22 has diagnosis of Depressive Disorder. On a Geriatric Depression Scale dated 4/08/08 R22's score was 1 (Score of greater than 5 is probable Depression). The MDS (Minimum Data Set) dated 3/06/08 states: R22 exhibits no memory or recall problems and has modified independence for decision making. R22 has persistent anger with self or others up to five days a week. MDS states R22 is 77 inches tall and weighs 277 pounds and is able to propel self around facility in his wheelchair. Current care plan dated 3/06/08 states, "Continue to monitor mood state and behaviors. Do interventions as appropriate." The care plan does not include what interventions are to be used for mood and behavior for R22. Social Service Progress Notes dated 9/20/07 state, "(R22) has mood swings. Is sweet and polite one minute then yelling and cursing the next."

On 4/29/08 at 9:00 a.m. R22 stateds, "Well, you know we're cousins so I've known (R21) for all of my life. (R21's) always been a gossip and she thinks she knows everything. When I hear her voice it gets to me. It's like hot air in my belly. It just comes up. I just see her in the dining room and I can feel it starting. Before, I never really ran into her much. It was hard for me when I first came, because I lived alone for years and it was hard for me to be around people. I just hear her voice, she talks loud and I can hear (R21). I just need to stay away from her. There's another one that kind of makes me feel that way (R17). She just sits there. She just bothers me sometimes. She knows it all."

On 4/22/08 at 11:20 a.m. R22 was propelling self in wheelchair to the dining room and stopping to speak with staff in hallway. On 4/24/08 at 1:45 p.m. R22 was noted in room sitting in wheelchair staring at wall and roommate (R25) present, resting on bed.

The following are staff/care giver interviews indicating knowledge of R22's verbally abusive behavior:

On 4/24/08 at 12:30 p.m. E3 (Director of Nursing/D.O.N.) stated, "(R22's) roommate was moved out for two nights and another time a CNA (Certified Nurse Aide) was getting him up and said he drew back his good arm as though he might hit her but he didn't. We don't really know if it was intentional. I talked to him. We moved (R21) in the dining room. We think it's a problem with his medications. (R22's) dilantin. (R22) yells at the nurses and at others too. It happens in the hall, dining room, or when (R22's) in his room." When asked if there were incident reports or investigations E3 (D.O.N.) stated, "No. It would be in the nurses' notes. No incident reports."

CONT.

On 4/25/08 at 3:45 p.m. E4 (Assistant Director of Nursing/A.D.O.N.) stated, "I heard about it and I passed (R21) in the hall and (R21) asked did I know about it and wanted to make sure I was aware. I said yes, I had heard and that was the end of the conversation."

Z1 (Attending Physician) on 04/25/08 at 2:25 p.m. stated, "I've taken care of (R22) for two years. (R22) goes in and out of being pleasant or agitated. I know he's mean to staff and screams. (R22) was doing this off and on, before the seizures this was happening. (R22) knows that he's grouchy. (R22's) screaming, yelling and that type of thing."

On 4/24/08 at 9:00 a.m. E13 (CNA) stated, "Three or four weeks ago, exact date I don't remember, (R22) was yelling at (R21). I tried to separate them and take (R22) to his room. (R22) was at the door (another resident's room). (R21) was dumb founded by it. It was in the evening after 6:00 p.m. I removed (R22) and got him to settle down and went to check on the ladies. (R22) said he was mad but didn't say why."

On 4/24/08 at 3:10 p.m., E14 (Licensed Practical Nurse/LPN) stated, "(R22) has always had a little bit of behavior but he just doesn't click with (R21). (R22) just doesn't like her. He yells and curses. They are right across the hall from each other." When asked if there was anything that sets off the behaviors E14 states, "No. Doesn't seem to be. It's been worse in the past few months. (R22) does it to the nurses too."

On 4/25/08 at 1:45 p.m. E21 (LPN) states, "I do believe (R22) does know who he is talking to when he does this. It's like impulse control is not there. I've never seen him not know who he was talking to."

On 4/25/08 at 1:50 p.m. E19 (CNA) stated, "Last time was a week or more. (R22) was in his room and (R21) was coming up the hall and (R22) came to the door. (R21) was talking to someone. He calls her a fat b---- and dumb. I don't think (R22) can control it. For awhile it was every other day and then it's like nothing happened. (R21) waits until (R22) goes out of his room to come out of hers. They've changed the seating in the dining room. (R21) shuts the door to her room when she's in there. (R22) has had her in tears more than once."

On 4/25/08 at 3:55 p.m., E7 (LPN/Licensed Practical Nurse) discussed a nurses note entry dated 04/01/08. E7 stated, "(R21) was going to visit her friends at the end of the hall and (R22) went down to the end of the hall and he kept telling her she talked too much and better shut up if she didn't he was going to slap her silly. (R22) was at the door. (R23 and R24) were there. It was their room. I hollered for (E13 CNA/Certified Nurse Aide) to come help. (E13) came down and told (R22) he couldn't act that way. (R22) kept saying (R21) never shuts up. (R21) was already in the room visiting when (R22) came down."

CONT.

On 4/29/08 at 7:30 a.m. E18 (LPN/Care Plan Nurse) stated, "There is one resident (R22) who does have inappropriate behavior with mostly yelling. Just yelling out loud and talking to her telling her that she is nosey, (R21)." When asked if R22 is cursing R21, E18 states, “Yes. (R22's) been known to use the f-word. (R22) always apologizes afterwards." When asked if R22 remembers and knows what he is saying, E18 (LPN) states, "Yes. It usually happens when (R22) hears her talk loud and (R22) hears her gossip."

On 4/29/08 at 2:05 p.m. E23 (Dietary Aide) states, "Yes, (R22) was hollering, picking on (R21). (R22) was yelling I don't know if he was cursing, I can't remember. (R22) was loud and trying to pick on her. Yelling and saying she killed her sister off. (R21) just tried to get away from (R22). She (R21) came out and went to the bird area but (R22) could still see her and kept yelling, 'There she goes, trying to hide.' (R22) could see her through the windows. (R22) was going on and on and trying to say she killed her sister off and she was a know it all. It wasn't only her (R21). A guy that sits at his table, (R22) went over and started cussing him. (R25), I think it's his roommate. Another day (R22) was picking on (R21) and (R17) within two or three days together two or three weeks ago. (R22) was calling (R17) a know it all and told her to mind her own business. (R22) was just loud all over the place. The dining room was full of residents both times and the aides came in to calm (R22) down and take him out. Several of the residents got upset and said they shouldn't have to put up with that. Both times it was in the morning at breakfast. (R17) spoke back to (R22) but (R21) didn't."

On 4/30/08 at 11:05 a.m. E22 (Social Services Designee) stated, "(R21) had come in and said (R22) had cursed her after she came back from an activity. (R21) talks loud all the time and I guess she was talking about the trip and (R22) was tired of listening to her mouth. (R21) told me (R22) yelled and cursed at her. (R22) said he was tired of her mouth running and her talking on the phone. I talked to her. About the only thing she (R21) said was I guess I'll just have to learn to keep my mouth shut. (R21) just had her feelings hurt. If I'd thought about it being abuse I would have talked to (E3/D.O.N.). A couple days later (R21) said she didn't want to move. I told her to shut the door." When asked if this fit the definition of abuse E22 stated, "Well, hurt feelings could be abuse. She (R21) was sitting with the other women, I think she just wanted sympathy."

R22's nurses’ notes from 12/28/07 through 4/21/08 contain ten entries regarding R22's abusive behavior and threats towards other residents in the presence of other residents and staff. Nurses’ notes provided the following information:

1/08/08 "(R22) very agitated this afternoon regarding roommate being put to bed after lunch. (R22) yelling at roommate, 'You son-of-a-b----! Take your glasses off so I can punch you.' R22 redirected by staff."

CONT.

3/29/08 at 7:00 p.m. "Resident called staff into room and said to tell the resident across the hall from him to shut up or he will go over there and smack her (R21) and she will shut up then." Nurses' notes continue to state R22 looked upset and his eyes were bulging.

4/01/08 at 8:30 p.m. "(R22) came out of his room, went to end room, calling out to female resident (R21) to come out and yelling, "Get the h--- out here and shut the h--- up. I'm going to slap you silly."

4/11/08 at 10:30 p.m. notes state while in his room with his roommate (R25) present R22 said to staff, "I need to f--- somebody. Call the doctor. He'll tell you." At 10:45 p.m. R22 yelling, "Call the doctor now! He will tell you that I need to f--- someone. Call him now!" R22 continued to yell and yelled louder when staff tried to speak with him.

4/11/08 at 11:00 p.m. R22 "Started yelling at roommate (R25). (E3/ D.O.N.) was called about (R22's) behavior and staff were informed to move (R22's) roommate (R25). (R22's) roommate moved at 1:30 a.m. and (R22) is still yelling."

4/12/08 at 1:30 a.m. nurses notes state (R22) still yelling at the air after roommate left. (R22) states, "All (R25) does is moan and groan and he might as well die." (R22) also yelling, "I can screw all the women here." Notes continue with R22 yelled rude profanity through the night until 5:00 a.m. the next morning upsetting and disturbing residents nearby keeping them awake.

4/12/08 at 8:00 a.m. nurses notes state: R22 noticed another female resident (R21) coming into the dining room and R22 began yelling, "That G--D--- B----! I want to slap her silly. All she does is run her f------ mouth." R22 then wheeled out of the dining room and into the hall but R22 came right back into the dining room yelling loud as he could, "I want to b---- slap that f------ b----! I will. I'd just like to slap the sh-- right out of her!" R22 continued to yell calling staff "You worthless lazy f------ c--- suck---, all you do is sit around and laugh at these d--- people." R22 refused to come out of the dining room and continued to curse about the staff saying, "You idiots think you know everything. I am going to slap all your faces off." R22 then came to his roommate's (R25) table and yelled at (R25), "You can f------ help yourself. You've got two hands! Do it da-- it!" Staff wheeled R22 out of dining room backwards. Nurses notes state the residents in the dining room were becoming anxious and yelling, "Get him out of here!" As staff were wheeling R22 out he yelled, "G--D--- you C---Suck---!" Staff took R22 to his room and shut the door but R22 rolled self into the hallway stating specific residents names and calling them "Worthless and stupid." The nurses notes state E3 (D.O.N.) was notified.

4/12/08 at 10:00 a.m. R22's nurses notes indicate: Resident's roommate (R25) refusing to go into room with resident. Roommate states, "Too anxious to deal with (R22) today."

CONT.

4/15/08 at 6:30 a.m. nurses notes state: R22 yelling, "Staff here ain't worth a sh--!" Notes continue with "Disturbing roommate and residents across the hall and yelling over top of staff's attempt to converse with him. Note states that resident across the hall (R21) is nervous about (R22's) behaviors. R21 stated, 'He kept us up all night. I'm not eating in the dining room with him.' R22 kept yelling stating, “This place is a f------ joke! Staff here sucks! What's wrong with yelling all night?"

4/15/08 at 8:00 a.m. "R22 yelling about another male resident being a f------ dumb ass. H--- he can't even get up and stand. He's f------ worthless."

4/18/08 at 7:30 a.m. nurses notes state E14 (LPN/Licensed Practical Nurse) was in hallway giving a female resident (R21) her medications. R22 came wheeling down the hallway yelling extremely loud, "Get the f------ fat ass b---- out of here!" E14's (LPN) nurses note indicates R21 quickly left and went to the dining room. R22 followed spotting R21 in the dining room and began yelling, "You f------ lard ass! Get the f--- out of here!" E14 (LPN) indicated R22 refused to leave the dining room yelling, "Well, that f------ lard ass doesn't need to be in here." E14's (LPN) nurses notes state residents in the dining room and hall becoming anxious stating, "Get him out of here! He's scaring us!" As staff wheeling R22 out of dining room backwards R22 yells, "Dumb f------ b----! F------ dumb sh--! All staff here are f------ dumb asses!" Nurses notes indicate E3 (D.O.N.) was notified and came and spoke with R22 at 8:05 a.m.

On 4/25/08 at 11:00 a.m. E3 (D.O.N.) verified the female resident mentioned in R22's nurses notes is R21.

Resident interviews provide the following information:

On 4/29/08 at 3:00 p.m. R17 stated, "There's been a couple of times (R22) swore and got mad. Once in the dining room (R22) said something sarcastic to me and I said something back. Staff came and talked to both of us. The residents don't like it. You wouldn't like it either."

On 4/24/08 at 4:20 p.m. when asked about R22 coming to her room R23 stated, "Yes, I remember it. You bet. It was about a month ago. I don't even think (R21) talked to (R22). She (R21) just came right down here (R23's and R24's room) to talk to us. (R21) was in the room and (R22) came on in the door yelling at (R21). (R22) was just focused on (R21). He didn't talk to us. (R22) was threatening (R21). I told him to get out of here. I wasn't going to put up with it. (R22) backed off a little bit but he didn't leave. I think someone had to come and take him away. I don't remember who did. It was awful. There's no call for that. I know (R22's) done it to her before. They tell them to just keep the doors shut but I don't think that does any good."

CONT.

R24 (also present during interview with R23 on 4/24/08) stated, "Oh, yes I was here. It was awful. It was scary. We didn't know what he (R22) was going to do. I don't know why (R22) does that to (R21). (R21) knows a lot of stuff and says what she wants and I don't think (R22) likes it. But there's no reason for that. (R22) doesn't bother us just (R21)."

On 4/25/08 at 11:20 a.m., R25 stated, "(R22) talks disrespectful, sometimes like a kid would. (R22) really doesn't belong here. (R22) yells. (R22) yells across the hall. (R22) yells at a lot of them, residents and staff." When asked if R25 was scared R25 stated, "Oh yeah, in the sense of I didn't know for awhile what (R22) would do next. They moved me out of there for two or three nights. That was nice. I got some rest but they moved me back." When asked if R25 wants a different room R25 stated, "Yes." Also asked if R25 had asked for a different room. R25 stated, "Yes, but nothing happens. (R22) has been quiet for about a week but you don't know if it will happen again." Physician Order Sheet (POS) dated 4/16/08 shows R25 (R22's roommate) is a 87 year old admitted on 10/23/07 with a diagnosis of Non Hodgkins Lymphoma and Arthritis. The POS states R25 is receiving chemo therapy and experiencing pain. An entry on R25's Nurses Notes dated 4/11/08 states, "Resident moved to (another room) due to roommate's loud, rude comments." R25's current care plan dated 4/17/08 does not contain interventions to address interactions with roommate R22.

On 4/25/08 at 11:10 a.m. Z2 (Occupational Therapy Aide) stated, "(R25) said he was having a hard time sleeping and it (R22's behavior) was disruptive."

On 4/30/08 at 1:35 p.m., R35 stated, "I was there in the dining room when (R22) talked to (R21) like that. (R22) said so many things he shouldn't have. (R22) told (R21) she killed her sister. Nobody should have to go through that and (R22) just kept on and wouldn't stop. (R22) kept saying (R21) killed her sister. It was very disrespectful, very upsetting." When asked if R22 was loud and cursing R35 stated, "Oh yes. (R22) was yelling. Oh yes, (R22) said lots of words we shouldn't have ever heard. (R22) just wouldn't let it go, kept on and on. I used to sit around there by (R22's) table but a spot came open by (R21) and I took it so I didn't have to be close to (R22)". When asked if other residents were upset R35 states, "Yes. Everyone heard it. Staff was there. (R22) calls them awful names too. I just try to stay away from (R22). You can hear him yelling in the halls, especially in the mornings. (R21) is the only one I've seen him do it to."

Review of R22's Behavior Flow Sheets on 4/29/08 at 10:50 a.m. shows mood swings were added as a behavior during May of 2007. Prior to May of 2007 withdrawn behavior was the only behavior being monitored. A Resident Assessment Protocol (RAP) used for care planning for R22's mood dated 3/03/08 and signed by E22 (Social Services Designee) states, "Mood RAP triggered due to being easily annoyed. This does not

NORTH ADAMS HOME | 0020925
Facility Name | I.D. Number

CONT.

happen often, however if staff or another male resident irritate him he will become angry which is easily altered. Will not proceed with mood."

E22 (Social Service Designee) verified on 4/30/08 at 11:05 a.m. that there are no social service notes regarding R22's behavior towards R22 and R25 and stated, "I don't make changes in the care plan, (E18/Care Plan Coordinator) does."

There were no new interventions observed added to R22's care plan for any of the incidents reported in the nursing notes. There was no evidence provided that there was ever any interaction from Social Services to deal with any of these behaviors.

In an interview on 4/29/08 at 7:30 a.m., E18 (Care Plan Coordinator) stated interventions to address R22's behaviors were added to R22's care plan but not until 4/25/08. E18 stated R22 had been moved to another room on 4/26/08.

The Facility Data Sheet indicates E3 (Director of Nursing/D.O.N.) is the designated Abuse Prohibition Coordinator.

E3 (D.O.N.) stated on 05/01/08 at 7:30 a.m. staff failed to identify the behaviors documented in the nurses notes of R22's record as abuse. E3 stated that the times staff called her to the area to deal with R22's behaviors she (E3) did not follow up with an investigation into the incidents.

The facility's policy titled "Abuse and Neglect/Theft Policy" with a review date of 2/08/08 defines verbal abuse as any oral, written, or gestured language that include disparaging and derogatory terms to residents, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. The policy states on page 10 under protection: every effort will be made to identify potentially abusive situations and prevent the occurrence if at all possible. The resident may need to be relocated in the facility. On page 3, the policy states for prevention: through the assessment process residents who are at high risk for being abused or of abusing others will be identified. When resident needs are identified, the care plan will address problems, goals, and approaches to reduce the risk of abuse.

Upon request by facility staff, no evidence of facility action taken into the behaviors of R22 and his abusive interaction with others could be provided until the change in R22's care plan was made on 04/25/08 and the room change for R22 on 04/26/08.

(A)