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	145948	A. BUILDING ______ B. WING ______	C 01/21/2009

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F9999	Continued From page 17 LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240b) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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) 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	F9999		

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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 Regulations were not met as evidenced by:

Based on interview, observation, and record review the facility failed to ensure that 2 of 10 sampled cognitively impaired residents (R2 and R6) were not subjected to repetitious abuse by the same staff perpetrator. Specifically, R2 was subjected to witnessed verbal, mental, and physical abuse followed by R6 being subjected to witnessed sexual abuse, all by the same perpetrator.

Facility staff also failed to immediately report 3 separate allegations of unwitnessed physical abuse made by 3 of 10 sampled residents (R4, R1, R7) at the hands of the same alleged male staff perpetrator (E3).

The facility also failed to thoroughly investigate 5 of 5 known allegations of abuse involving 4 residents (R2, R3, R4, R6). The facility failed to document evidence of a an assessment being conducted for 4 of 10 sampled residents (R2, R6, R4, R3) who were subjects of alleged abuse to determine their physical and psychosocial status following receiving reports of alleged abuse, pursuant to facility policy.

Findings include the following:

1. On 1-13-09 at 3:35 p.m. Certified Nurse Aide

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F9999	Continued From page 19 (CNA), E6, stated she witnessed CNA, E4, mentally and verbally abuse R2 in R2's bedroom during one day "the first week of January (2009) "between 10:30 and 10:45 a.m.. E6 stated that she was present in R2's bedroom providing care to R9 in the adjacent bed and witnessed E4, while providing services to R2, state "I hate retards." E6 stated that R2 was observed to thrash about in her bed while she was being prepared for a mechanical lift transfer. At this time E4 spoke to R2 referring to her as a "little bitch." According to E6 no further incident was observed with R2 at this time. E6 stated that she did not report what she had observed until 1-9-09 when she notified E1, Administrator/Abuse Prohibition Coordinator. E4 continued to provide direct resident care. 2. On 1-13-09 at 12:25 p.m. Unit Aide, E5 stated she witnessed E4 mentally, verbally, and physically abuse R2 in R2's bedroom "sometime the first week of January (2009). E5 stated that she was present in R2's bedroom by R10's bed when she observed E4 transferring R2 in the mechanical lift from the bed to the chair by himself. R2 was observed to be thrashing about, moving her head forward and backward on and off of the headrest of her adaptive wheelchair. E5 stated that E4 stated to her (E5) "I hate retards." E5 stated that she observed E4 state to R2 "stop it you retard." E5 stated that E4 then pushed R2's head on the side of her face, with his fingers extended, against the headrest. E5 stated that the contact E4 made with his hand against R2's face appeared rough rather than gentle in nature. E5 demonstrated the forceful nature that she observed E4 use against R2. E5 stated that she did not report what she had	F9999		

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observed until 4 or 5 days after it had occurred. E4 continued to provide direct resident care.

R2's Face Sheet and Physician Order sheet dated 1-16-09 reflect that R2 is a 52 year old female with diagnoses including Profound Mental Retardation, Cerebral Palsy, Schizoaffective Disorder, Dementia, Bilateral Cataracts, and Osteoporosis. R2's Minimum Data Set (MDS) dated 11-13-08 reflects that she has impaired memory, severely impaired cognitive/decision making abilities, is totally dependent on staff for activities of daily living, incontinent, has socially inappropriate/disruptive behaviors, exhibits crying and repetitive physical movements, has little or no ability to understand others, and can only communicate by signs, gestures, and sounds. R2 can hear adequately but has severely impaired vision. R2's most recent plan of care dated 12-8-08 reflects that when she is up in a chair she has constant non-purposeful movement and forward flexion.

3. On 1-13-09 at 1:30 p.m. CNA, E8 stated she witnessed E4 sexually abuse R6 in R6's bedroom on 1-8-09 sometime between 6:30 and 8:00 p.m. E8 stated that she was present in R6's bedroom at the time assisting E4 to get R6 ready for bed. E8 stated that R6's upper body was not clothed while she was seated in her wheelchair. E8 stated she observed E4 to "smack" or "tap" R6's (breast) with his open hand. E8 stated that E4 laughed as did R6 immediately following this interaction. E8 stated that R6 has some confusion and is not "in her right mind." E8 stated that no further incident occurred as R6 was clothed and put to bed. E8 stated that she viewed E4's touching of R6's breast to be

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inappropriate and considered it to be abusive. E8 demonstrated E4's observed actions against R6 to Z1, representative of the County Sherrif's Office present during the interview, which appeared to be willful, and was presented as a light tap with an open hand, and was further described by E8 as "offensive" in nature. E8 stated that she did not report the incident to E1 until the next day. E4 continued to provide direct resident care.

According to R6's Face Sheet and 1-16-09 Physician Order Sheet she is a 78 year old female with diagnoses including Dementia, Depression, Congestive Heart Failure, and Neuropathy. R6's MDS dated 1-6-09 reflects that she has impaired memory, severely impaired cognitive/decision making abilities, requires limited to extensive assist with activities of daily living, and is incontinent. R6 has no behaviors, is independent with ambulation, no range of motion limitations, and can see and hear adequately.

Review of R6's clinical record yielded no evidence of any physical assessment being completed related to E8's allegations against E4. E1 and E2, interviewed on 1-15-09 at 3:20 p.m. confirmed that there was no documented assessment completed due to the delay in the allegation being reported to them.

An attempt to interview R6 on 1-14-09 at 10:50 a.m. yielded no evidence that she was able to recall this event.

In interview with E4 on 1-15-09 at 1:45 p.m., E4 denied all allegations against him.

According to E1 on 1-14-09 at 9:00 a.m., E4

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continued to have access to residents in that he was permitted to work until near the end of his shift on 1-9-09 when E1 became aware of the allegations against E4.

On 1-14-09 it was determined that beginning in "the first week in January (2009)" R2, R6, and other cognitively impaired, staff-dependent residents were put at risk for potential further abuse and harm by E4's unrestricted access to them. These residents were identified to be at risk due to repetitious failures to promptly identify, report, and investigate allegations of abuse.

4. Interview with E1 and E2 on 1-13-09 at 10:30 a.m. reflected an awareness of an unwitnessed allegation of physical abuse toward R3 by E3 that reportedly took place on 1-10-09.

Review of an untitled investigative summary dated 1-10-09 and completed by E1 reflects an allegation against E3 by R3 at 8:30 a.m. stating "he is crazy and he pulled my hair".

Review of the investigative report and documentation collected by E1 showed there is only a single signed written statement by one witness (E11). Statements documented by E1 were recorded on behalf of the alleged perpetrator (E3), and R3.

Interview with E12, Licensed Practical Nurse, on 1-16-09 at 9:45 a.m. reflects that she was working as charge nurse when R3 made the allegation on 1-10-09. E12 stated that upon being brought to the Dining Room for breakfast on 1-10-09 it was reported to her by staff (E6, E14, and E5) that R3 appeared more anxious

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than usual, that she appeared scared, and was shaking. E12 stated that R3 reported to staff that "he grabbed my arm and pulled my hair". E12 indicated that R3 had just been brought to the dining room following a.m. care given by E3, the only male caregiver working that morning. Following this report E12 notified E1 of the allegation and removed E3 from further resident contact pending investigation.

E12 stated she conducted an assessment of R3 which showed a reddened area on her left shoulder and 3 red scratches/imprints across the posterior left arm which resembled marks from fingers. E12 stated she examined R3's scalp with no findings. E12 stated she did not document the results of her assessment per usual protocol. When asked why she did not document the assessment, E12 stated she was told by E1 "not to document anything, that (E1) would take care of it."

E12 stated she, R3 and E1 met to discuss the allegations at which time R3 also stated that "he yanked the covers off of me."

Review of all available documentation related to this incident yielded no evidence that R3's allegations of her arm being pulled and her covers being yanked off of her were ever investigated. There is no documented evidence that pertinent potential witnesses were interviewed during the investigation including E5, E6, E10, E12, E14, and R5 (R3's roommate). E1 confirmed in interview on 1-14-09 at 11:20 a.m. that there may have been discussions with some of the above witnesses but they were not documented.

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According to E1 and E12, E3 was permitted to return to the floor to provide direct care the same day.

5. Interview with E1 and E2 on 1-13-09 at 10:30 a.m. reflected an awareness of an unwitnessed allegation of physical abuse toward R4 by E3 that reportedly took place on 1-11-09.

Review of a facility incident report dated 1-12-09 completed by E1 reflects that R4 made an allegation on 1-11-09 at 4:45 p.m. to E8 that E3 "was hurting his legs." The report states that E3 was suspended pending investigation.

Review of E12's written statement dated 1-12-09 states "...(R4) expressed that (E3) had hurt his legs...he was squeezing them while getting him dressed (and) it hurt. He also stated he was pulling on them that was painful also." A similar concern was detailed in CNA, E7's written statement. E8's statement dated 1-11-09 reflects that she had asked R4 at 4:45 p.m. how his day was going and R4 responded that it "...was a bad day...a man who works here with dark hair and glasses hit him on his sore penis and on his leg."

Interview with E7 on 1-13-09 at 1 p.m. reflected that she was made aware of R4's allegation of being hit by E3 on his legs on 1-11-09 between 10:30 and 11:00 a.m. According to E7 she reported this allegation to the charge nurse, E12.

Interview with E12, Licensed Practical Nurse, on 1-16-09 at 9:45 a.m. reflected that she was made aware of R4's allegation by E7 that E3 "was really rough with his legs" on 1-11-09 at which time she notified E1 per telephone. According to

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E12, E3 was permitted to complete his shift and had unrestricted access to residents.

Further interview with E12 reflected that she became aware of an allegation from E8 later in the afternoon on 1-11-09 that E3 had hit R3 on the penis. E12 stated she again notified E1 of an allegation. E12 stated that E3 had already completed his shift and had left for the day. E12 stated that it did not occur to her to remove E3 from the floor. E12 stated that she "figured (E3) would be put back on the floor to work."

When questioned about a documented assessment of R4's alleged physical abuse she stated that she conducted a full body assessment but did not document the results. When asked why she did not document the assessment she stated she had been told the previous day not to document. She stated "I assumed (E1) would handle it".

Review of E1's documented investigation yielded no evidence that R4's allegation of being hit on the penis was ever investigated.

6. Interview with E5, Unit Aide on 1-13-09 at 12:00 p.m. reflected that she was aware of two allegations of mistreatment of residents that she failed to immediately report pursuant to facility policy.

At this time E5 stated in interview that she was made aware through another staff person (E6) that R7 was witnessed to have been "smacked on the bottom" by E3. E5 stated that she had no other details and admitted to failing to immediately notify E1 of the allegation.

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F9999	Continued From page 26 At this time E5 stated in interview that she had been made aware " a few days earlier" by R1 that E3 had treated him roughly. E5 stated that she had no other details and admitted to failing to immediately notify E1 of the allegation. Facility policy titled Abuse Prevention Program under section IV. Internal Reporting Requirements and Identification of Allegations states "Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator." (A)	F9999		