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	145615	A. BUILDING _____ B. WING _____	C 05/13/2009

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COVENTRY LIVING CENTER	**612 WEST ST MARY'S STREET STERLING, IL 61081**

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F 225	Continued From page 13 pending the facility investigation. 2. The facility had initiated an investigation. 3. Full body assessments were completed on 100% of the residents in the facility. 4. All staff were inserviced on the facility abuse policy to include procedures for identification and reporting of bruising/injuries of unknown origin. 5. The facility will assess the interventions on a quarterly basis as a part of their Quality Assurance Program to evaluate the plans effectiveness.	F 225		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a) 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. 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.	F9999		

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F9999	Continued From page 14 These Regualtions were not met as evidenced by: Based on Observation, Interview and Record Review, the facility failed to identify and investigate bruising of unknown origin for R1. This resulted in a 3 day delay in removing the staff member from resident care. This had the potential to affect all 95 residents in the facility. The examples include: R1 is a 69 year old female admitted to the facility on 3/10/09 with a diagnosis of Exacerbation of Chronic Heart Failure (CHF) according the the Physician Order Sheet (POS) dated 5/09. On 5/5/09 at 3:50 PM, E4 (Licensed Practical Nurse - LPN) stated R1 told her on 5/1/09 that she had asked both CNA's (E5 & E7) on two separate occasions that evening to assist her (R1) to bed but was "put off." E4 said she asked E5 to assist R1 to bed and E5 began expressing her frustration with E7. E5 told E4 she was "upset" with E7 as she had not been doing an equivalent portion of the work. E4 verbalized she went with E5 to assist the patient because "I knew E5 was in a huff." E4 stated E5 began pushing R1's wheelchair without really watching what she was doing because E5 was "angry" about the workload distribution. E4 said E5 "shoved R1's feet into the closet. R1 let out a yelp." E4 said R1 then stated she did not want E5 or E7 to provide care to her. E4 said she told E5 to leave the room. On 5/6/09 at 3:30 PM, E4 verified she left R1's room on 5/1/09 after telling E5 to stop providing care to R1 but left the room prior to ensuring E5	F9999		

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F9999	Continued From page 15	F9999		

left the room. E4 stated she left R1's room to enlist the help of two different CNA's. E4 verified when she returned to R1's room with E9 (CNA) and E10 (CNA), E5 was still in R1's room.

In the Facility Policy and Procedure Manual for Abuse, on page 10C under Emotional Symptoms of Excessive Stress, the fourth bullet point identifies "Feeling overwhelmed with responsibilities" as a concern to be identified and addressed.

On 5/6/09 at 3:45 PM, E1 (Administrator) stated she would expect anyone exhibiting signs of burn out to be separated from the residents and given time to calm down and if that was not effective the individual should be sent home. E1 also verified that if any unusual incident or problems with staff occurred, it is expected that the staff would notify her (E1) or E3 (Director of Nursing - DON) at the time of the event.

During the interview on 5/5/09, E4 stated she did leave a note for the Director of Nurses (DON) regarding the situation but did not call anyone. This action would have occurred on Friday night after 10:00 PM resulting in no one being made aware of the situation until Monday 5/4/09. E4 stated she was off on 5/2/09 and 5/3/09 but that she did make sure to notify E3 in person on her return to work on the 2:00 PM - 10:30 PM shift on 5/4/09 (Monday). The schedule shows E5 worked the 2:00 PM - 10:30 PM shift on 5/4/09.

On 5/5/09, this surveyor entered the facility. E1 stated at the entrance conference she had "just" become aware of the concerns after being called by the Hospital personnel. E1 stated they are beginning the investigation now. This is 3 days

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F9999	Continued From page 16 after the alleged incident and 24 hours after E4 stated she verbally notified E3. On 5/7/09 at 10:45 AM, an interview was conducted with E5. E5 exhibited several inconsistencies in her account of the incidents that occurred on 5/1/09. As the interview progressed, E5 was observed becoming more physically agitated. E5 was clenching her fists or clenching tightly to the arms of the chair and letting out numerous deep sighs of frustration when questions were posed. By the end of the interview, E5 stated she was in R1's room during the time of the alleged incidents, that E4 was with her in R1's room initially but left her alone when she (E4) left to seek other assistance. Review of the Nursing Note dated 5/5/09 for the 10:00 PM - 6:00 AM shift showed R1 with no skin discolorations but requiring total assist with all activities of daily living (ADL's). R1's care plan dated 3/18/09 for Potential for Alteration in Skin, showed an approach to be completed by nursing staff is "skin check daily during care Report abnormalities such as open Areas, edema, discoloration, redness that does not go away, warmth." Z1 (Hospital Registered Nurse) documented on 5/5/09 at 9:00 AM, "large hand shaped bruise on midback noted to left & right side. Bruises hardened feeling. Dark purple. Finger shapes" visible. A second Emergency Room Note from the hospital dated 5/5/09 at 9:00 AM reads "Checking in Pt. (Patient) Took off top found bruising to both right and left flank area. Patient states nurse through (threw) her into cabinets at the Nursing home. Pt. says nurse became mad. . . . .These are hand prints on her in bruising	F9999		

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F9999	Continued From page 17 area." Observations of R1's bruised areas by this surveyor on 5/5/09, found R1 to have bilateral large dark purple and black bruises to her upper (posterior) flank area. These bruises were easily identifiable as hand prints with some yellow discoloration being noted at the edge of the finger areas. These hand prints showed a right hand print on R1's right flank and a left hand print on R1's left flank indicating the individual was behind R1. The finger markings extended medially (towards the spine) with the thumb markings at the lower most portion of the bruising extending towards the ground. R1 had non-distinguishable but extensive bruising to the right thigh and hip. According to Health Assessment in Nursing by Sims, D'Amico, Stiesmeyer and Webster, a bruise "begins as bluish purple mark that changes to greenish yellow" as the healing process progresses. R1 was noted to have some yellowish areas at the edges of the finger tips when this surveyor observed the bruising. This indicated the brushing had been visible for more than a day. R1's thigh, hip and flank areas were all of the same color and stage of healing which showed R1 sustained these injuries in a short time frame of each other. E4 explained how and when the hip and thigh bruising occurred. E4 identified during her interview on 5/5/09 that on 5/1/09 when E9 and E10 came to R1's room to assist in R1's transfer, R1's legs gave out resulting in R10 reaching down and grabbing R1 by the thigh to prevent her from falling and then moved hand up near her buttocks on the right side to assist and guide the pivoting motion for R1 to be placed on	F9999		

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F9999	Continued From page 18 the commode. R1's contusions on her hip and thigh are on the right leg which is where E4 stated E10 grabbed R1 on 5/1/09. During an interview on 5/7/09 at 2:25 PM, Z2 (Hospital Medical Assistant) stated she and Z1 (Registered Nurse) attended to R1 upon her arrival to the emergency department on 5/5/09. Z2 stated R1 had overt purple-bluish hand print bruising to her bilateral flank areas. Z2 continued to state that R1 verbalized she had been pushed by a staff member at the nursing home. Z2 continued to elaborate on R1's fearful demeanor and her expressed relief at being able to tell someone what happened. Z2 told this surveyor that E3 (Acting Director of Nursing) called the emergency department after this surveyor entered the nursing home building and asked the emergency department personnel to keep the details of the findings "Hush Hush." Z2 stated she was appalled at the actions of the nursing home and hoped R1 did not have to return to that facility. On 5/12/09 at 9:30 AM, Z1 stated while R1 was in the admission process at the hospital, she (Z1) identified "extremely obvious hand prints" on R1. Z1 stated the outline of the fingers were clearly visible with the palm areas were dark purple/blue in color. Z1 said R1 told her a staff member at the nursing home "beat" me and "threw" me against a counter. Z1 expressed in her professional opinion R1 was handled more roughly than necessary to complete any Activity of Daily Living (ADL). Z1 verbalized that extreme force had to have been used to create the depth and extent of bruising visualized by herself. Z1 stated she called the facility to speak with the DON and ask if the bruising had been identified	F9999		

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F9999	Continued From page 19 by the staff. E3 spoke with Z1 and was made aware of the hospital's concerns. Z1 said E3 responded by stating "don't do anything about them (reporting the bruises) until after I am gone because I'll be gone on May 22nd." Z1 stated E3 attempted to call her again later in the AM but Z1 was busy and unable to accept the call. Z1 stated she returned the call to E3 at "about 10:30 AM" on 5/5/09. Z1 said at this time E3 told her she (E3) had spoken to the nurse on duty the prior night (E4). Z1 said E3 was told by E4 that a CNA (E5) attempted to assist R1 to transfer without the use of a gait belt and was unable to do so and they (E3 & E4) felt that bruising occurred as a result of that action and again asked Z1 not to report her findings. (A)	F9999		