STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145919	A. BUILDING ______ B. WING ______	C 07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKFORD NURSING & REHAB CENTER	**1920 NORTH MAIN STREET** **ROCKFORD, IL 61103**

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F9999	FINAL OBSERVATIONS	F9999		

FINAL OBSERVATIONS

LICENSURE VIOLATIONS

300.610a)
300.3240a)
300.3240c)
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)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a

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F9999	Continued From page 19 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 regulations are not met, as evidenced by the following: Based on interview and record review, the facility failed to prevent staff from verbally and mentally abusing residents. E19 (LPN) threatened a resident (R3) by telling him he was going to move an aggressive resident into his room. He also to called a resident (R4) with mental retardation and cognitive impairment a derogatory name in the presence of other residents and staff. He allowed and prompted a cognitively impaired resident (R7) to call him a name with sexual implications, and verbally taunted a resident (R4) with mental retardation causing an escalation in behavior. These failures resulted in R3 becoming upset and crying. R7 was laughed at by other residents and staff when she used an inappropriate name for E19. R4 became so agitated on 7/10/10 he had to be sent to the hospital for evaluation. These areas of abuse apply to 3 of 44 residents residing on the second floor (R3, R4, and R7). The examples include: 1. R3 has diagnoses of Cerebral Vascular Disease, Seizure Disorder, Hypertension, Depression, Anemia, Atherosclerotic Heart Disease, and Chest Pain per the Physician's	F9999		

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F9999	Continued From page 20 Orders for July 2010. The assessment of 4/29/10 shows that R3 has a short term memory problem and is moderately impaired in his ability to make decisions. On 7/16/10 at 9:10 AM, during a confidential interview, it was determined that E19 (LPN) threatened R3 by saying he was going to move R4, a former kick boxer with behavior problems, into his room. R3 became upset and started to cry. On 7/16/10 at 2:10 PM, E19 (LPN) said that he did tell R3 he was going to move R4 into his room. E19 said that one morning he came on the unit and R3 did not say good morning to him. E19 said to R3, "What's the matter aren't I good enough for you to talk to anymore?" E19 then said that he told R3 he was going to put R4 in his room. E19 said he told R3 this because he always gets the problem residents as roommates. 2. R4 has diagnoses of Hypertension, Diabetes, Mild Retardation, Chronic Undifferentiated Schizophrenia, and Depression per the Physician's Orders for July 2010. The assessment of 3/17/10 shows that R4 has no short or long term memory deficits. On 7/16/10 at 9:00 AM, a confidential interview was conducted. The CNA interviewed said that E19's behavior is awful. "I do not know what his problem is. I do not know if he (E19) is crazy or what." The CNA reported that on 7/10/10, E19 was taunting R4 and got him very agitated. R4 became very upset and was yelling at E19 telling him to leave him alone. The Nurse's Notes document that R4 was sent to the hospital at	F9999		

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F9999	Continued From page 21 12:35 PM, related to increased agitation and physical aggression. E19 also calls R4 a "f***king retard" in the dining room in front of other residents and staff. E1 met with E18 (CNA) on 7/13/10 at 11:30 AM. E18 expressed her concerns about E19's behavior to E1 (Administrator) at that time. 3. R7 has diagnoses of Dementia, Hypertension, Transient Ischemic Accident, and Depression per the Physician's Orders for July 2010. The assessment of 6/23/10 documents that R7 has short and long term memory deficits and is moderately impaired in her ability to make decisions. On 7/15/10 at 4:40 PM, E18 (CNA) said that E19 tells R7, a cognitively impaired resident, his name is "Harry Peter". R7 then calls out for E19 using the name "Harry Peter." Staff and other residents laugh when R7 does this. On 7/16/10 at 9:00 AM, during a confidential interview, a CNA said that R7 really believes E19's name is "Harry Peter." On 7/16/10 at 2:10 PM, E19 (LPN) said that R7 sometimes calls me "Harry." Other times R7 calls me "Peter." In some cases she puts them together and calls me "Harry Peter." On 7/16/10 at 2:25 PM, E1 (Administrator) agreed that the above mentioned conduct by E19 was not appropriate for any staff providing direct care to residents. Staffing schedules show that E19 continued to work in the facility as a nurse. E19's last day of work was 7/16/10.	F9999		

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F9999	Continued From page 22 The facility's Abuse Prevention Program Procedure states that verbal abuse is "the use oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability...." On 7/7/10, E1 (Administrator) was made aware of allegations of abuse, by the Illinois Department of Public Health, involving E19 (Licensed Practical Nurse - LPN). On 7/16/10 at 12:20 PM, E1 said that he had not done any abuse investigations in the past two weeks and had not suspended any staff related to allegations of abuse. E1 said that he had been conducting one to one (1:1) interviews and education with staff. E1 said that he had interviewed 20 staff members from 7/12/10 through 7/15/10. He said that none of the staff had any concerns or allegations regarding abuse, were not fearful of reporting concerns to him, and no one had concerns regarding E19. E1's notes from his meetings with staff were reviewed. The notes show that out of 20 staff interviews, five staff (E16, 18, 18, & E20-22) expressed concerns regarding inappropriate behaviors of E19 and fear of being terminated if they expressed their concerns regarding E19 to E1. The July 2010 nursing schedule shows that E19 continued to work his scheduled hours on the 2nd floor. E19's employee file was reviewed. There were no disciplinary actions in the file. During a confidential interview it was stated that	F9999		

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F9999	Continued From page 23 on the weekend of 7/10 and 7/11/10, there were additional abuse allegations involving E19's interactions with R3, R4, R7. The facility's Handbook for Professional and Administrative Staff, April 2009 states, " (page 18) While it is impossible to name every conceivable offense, the following list is illustrative of the kind of behavior that is unacceptable to the facility: 3. Engaging in abusive, discourteous, profane, indecent or unprofessional language or conduct while on duty or on facility property. 4. Engaging in words or actions that violate the residents' legally protected rights. (Note: This includes but is not limited to threatening, intimidating, or abusing residents in any way - physically, mentally, verbally, sexually, etc.)...." (A)	F9999		