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	146023	A. BUILDING ______ B. WING ______	11/09/2010

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F 490	Continued From page 27 Coordinator, will notify the Administrator and ADON(Assistant Director of Nursing) of any allegation and will seek assistance as needed with investigations. When the investigation is complete the DON will discuss the conclusion of the investigation with the Administrator and ADON and determine if any disciplinary action will be taken. Staff not present for the training will not be allowed to work until they receive the training. 11/5/10-Staff and Administrative staff including the Administrator were inserviced on the Abuse Policy changes, how to identify abuse and acts that could potentially be abuse of a resident by Z2, Elder Care Case Worker. 11/8/10-The Administrator and DON will be retrained on the recognition and investigation of potential abuse by Z3, Attorney. 11/8/10-Abuse investigation conducted by the facility will be reviewed by Z4, Social Service Consultant, for the next 60 days.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240c) 300.3240d) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by	F9999		

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F9999	Continued From page 28 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (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 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	F9999		

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3-611 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to follow its policies and procedures, and regulatory requirements, as follows. The facility failed to identify reported instances of mistreatment and theft as allegations of potential abuse for 5 residents (R4, R8, R11, R12, R13) on the sample of 14 and 2 supplemental residents (R15, R16). The facility failed to investigate a reported allegation of mental abuse (R16) and ensure residents were protected from further potential abuse. These failures resulted in further mental and physical abuse for R11, with the same staff member pulling the front of R11's shirt up over her face, tucking the shirt behind R11's head, in retaliation for R11 spitting at the staff member. The facility failed to report, thoroughly investigate, document, and protect residents from potential further abuse for 4 reported instances of theft (R8, R12, R13, R15), 1 reported instance of physical/mental abuse (R11), 1 reported instance of mental abuse (R4), 1 reported instance of physical abuse(R4), and 2 reported instances of neglect (R4).

Findings include:

1. E7, CNA (Certified Nurse Aide), stated on 11/4/10 at 1:00pm she witnessed E8 and E9, CNAs, teasing R16. E7 stated E8 and E9 were teasing R16 about R16 "talking about sex." E7 stated R16 was getting more and more agitated, trying to get up out of the chair when either E8 or E9 grabbed R16's nose and said "you need to quit." E7 was unable to remember which CNA

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grabbed R16's nose. E7 stated she could not remember the exact date of the incident, but thought it occurred during the summer, after the evening meal. E7 stated she reported the witnessed incident to E1, Administrator.

E1, Administrator/Abuse Coordinator, stated on 11/4/10 at 2:35pm that he was not aware of the allegation of staff teasing R16 until Z1, State Surveyor, told him of the allegation. E1 stated he had no investigation of the incident. E1 confirmed on 11/5/10 at 10:05am he was not aware of the allegation of staff (E8,E9) teasing R16 until Z1 told him sometime between 7/29 to 8/2/10. E1 stated he did not investigate the allegation because "[Z1] was here investigating."

2. E10, CNA, stated on 11/4/10 at 12:05pm that on 11/2/10 between 2:00 and 3:00pm she was asked by E9, CNA, to help toilet R11. E10 stated R11 was "extremely combative" and was hitting, biting and scratching at the time of the care. E10 stated R11 was sitting on the commode and E9 was in front of R11 trying to change R11's pants. E10 stated, "I was behind [R11] trying to calm her, with my hands on her upper arms, so [R11] couldn't scratch [E9's] face." E10 further stated, "[R11] started spitting, the spit got in [E9's] face," which made E9 "angry." E10 further stated, "[E9] stepped away from [R11], then came back over to [R11] pulled the front of [R11's] shirt over [R11's] head and looped it on the back of [R11's] head. The shirt was so tight, you could see the outline of [R11's] face." E10 further stated that E9 told R11, "You think you're going to spit on me!" E10 further stated, "[E9] was angry, she was punishing [R11], it was a punishment." When asked how R11 reacted to the situation E10 stated, "It was not on [R11's] face for very long-

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[R11] panicked and was reaching for her shirt." E10 stated she started to reach for the shirt to remove it from R11's face and then E9 removed the shirt from R11's face. E10 then took R11 and gave her a shower. Throughout the shower R11 kept saying "I didn't hurt her, I didn't hurt her." R11 was "aware of what happened, kept kissing my hands, because I didn't hurt her." After her shower R11 still remembered the incident, because R11 saw E9 and stated, "She thinks she's so smart." E10 stated she thought E9 left the facility on 11/2/10 about 3:00pm. E10 did not immediately report the incident with E9 and R11 because "I was not sure what to do." E10 stated she left the facility about 3:30pm that day (11/2) and that evening called E11, LPN(Licensed Practical Nurse) at home. She asked E11 if she thought this was "abuse." E11 instructed her to call E1,Administrator/Abuse Coordinator. She called E1 and E3, ADON (Assistant Director of Nursing) on the evening of 11/2/10 and reported the incident between R11 and E9.

The facility report titled "Documentation" dated 11/1/10 was reviewed. The report states E10 reported the incident with E9 and R11 to E1 on the evening of 11/1/10. E10 reported that R11 was combative while being changed and spit at E9 while she was removing her clothes. E10 reported that E9 pulled R11's shirt up and over R11's face. The report documents on 11/2/10 at 8:00am, E1 and E3,ADON, met with E9 to discuss the incident the previous day with R11. The report documents that E9 reported the facts "essentially as [E10] had. [E9] expressed that she felt [E10] could have provided more assistance in helping to keep [R11] from swinging her arms and hitting. [E9] said that she had pulled [R11's] shirt up over her face to keep her from spitting on

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F9999	Continued From page 32 her again..... I [E1] told [E9] that I did not think it was 'abuse' because there was no intent to harm and I did not believe there was any harm to [R11].....While this was not the most patient, kind, nor caring response to [R11's] aggressive behavior, I [E1] do not believe it was abusive, [E9] was allowed to return to work and no further action was taken." E1 confirmed on 11/5/10 at 9:30am that the incident between E9 and R11 occurred on 11/2/10, not 11/1/10 as he originally thought. E1 provided a "Documentation" report with the corrected dates of 11/2/10 and 11/3/10 respectively. E1, Administrator/Abuse Coordinator, stated on 11/4/10 at 2:35pm that E10 called him at home and reported the incident (11/2) with R11 and E9. E1 stated he called the facility and found out E9 was not scheduled to work the next day (11/3) until 7:30 or 8:00am., so he instructed staff to not let E9 work until he was able to talk with E9 in the morning. E1 stated he and E3 talked with E9 the morning after the incident and the "stories were basically the same-[R11] was agitated, combative and hitting. [R11] spit at [E9] and some of the spit went in [E9's] mouth. [E9] said she pulled [R11's] blouse up to stop her from spitting. I didn't think it was abusive." When asked who he talked to for his investigation, E1 stated he talked to E9 and E10 about the incident, but no other staff or residents, including R11. E1 stated he talked to E10 on the phone when she reported the incident, but did not talk to E10 at any other time about what happened with R11 and E9. E1 stated, "I didn't consider it an investigation." E1 confirmed that after he talked with E9, E9 worked the rest of the day providing care to residents (11/3).	F9999		

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E10, CNA, stated on 11/4/10 at 12:05pm that when she came to work on 11/3/10, E9 was "still on the floor working, working with [R11] the next day." E10 stated she talked with E1 the next day (11/3/10) and was told by E1, "[E9] told [E1] that I [E10] wasn't doing what I[E10] needed to, to calm [R11]."

3. During a group meeting with residents identified by the facility as being interviewable on 11-4-10 at 10:00am, information was supplied by R8 and R12 which indicated that there have been problems with money missing from their rooms. The group stated that concerns with theft of money had been reported to the facility staff including E1, Administrator. The group stated that money ranging in amounts of $12 to $34 had gone missing in June and July of 2010 from the bedrooms of R8, R12, R13, and R15.

Grievance/Complaint forms maintained on file reflect documentation of complaints received of missing money between 6-9 and 6-11-10 by R8 ($20 from billfold), R12 ($24 from billfold), R13 ($11 from glasses case), and R15 ($25 from her side table). Documented resolutions to these complaints included that residents should not keep money in their rooms, should keep money locked up, or secure money in the resident trust fund account. There was no documented evidence of any investigation being conducted with regard to alleged theft.

E1, Administrator/Abuse Prohibition Coordinator, stated on 11-4-10 at 11:55 a.m. that he was aware of the alleged missing money but had not documented any investigation. E1 stated that he could not recall if he interviewed residents alleging missing money. E1 stated he did not

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attempt to interview potential witnesses including residents, staff, or visitors. E1 stated he did not collect any written statements from potential witnesses nor did he contact, consult, or involve the police. E1 stated that there had also been alleged theft from staff by a (potential/alleged) staff perpetrator identified who was not interviewed with regard to these allegations. E1 stated that this alleged perpetrator (E5, Certified Nurse Aide) continues to work as a direct care giver in this facility.

E1 failed to identify these complaints of missing money as allegations of theft (misappropriation of resident property). E1 stated that he did not report any of the alleged theft allegations to the State Survey and Certification Agency and that it has never been his practice to do so. E1 stated at this time that he "should have been more thorough."

4. On 11-3-10 at 2:40 p.m. R4 related the details of an incident that she recalled occurring in August 2010. R4 stated that E12, Registered Nurse mistreated her in front of her peers during an organized activity whereby she was embarrassed/humiliated.

R4 stated she recalled that E12 administered her oral medication during a bingo activity in the activity room and "she made me stick my tongue out to make sure I swallowed it." When asked how this made R4 feel she replied that it made her "feel stupid...like a 2 year old."

R4 stated that this incident was reported to E2, Director of Nursing. E2 denied awareness of this allegation on 11-3-10 at 4:10 p.m.

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On 11-4-10 at 8:40 a.m. E1, Administrator stated he was aware of this incident. E1 described the details of the incident as R4 had described it and indicated he was aware that R4 "didn't like it" and that it "made her feel like a child." E1 stated that he did not view the incident as an allegation of mistreatment/abuse but agreed that E12 should have acted differently, in a more private setting.

E1 stated that he spoke with E12 about the incident the following day and that E12 admitted to him that she had instructed R4 to stick her tongue out during the bingo activity in the presence of her peers. E1 stated he did not conduct and document an investigation, did not interview any potential resident or staff witnesses, did not report the allegation to the State Survey and Certification Agency, and did not take measures to remove E12 from resident contact as an alleged perpetrator of mental abuse.

E12 continued to have unrestricted access to residents up to and including 11-4-10 when she was working in the facility at 5:00 p.m.

R4's 11-2010 Physician Order Sheet reflects that R4 has diagnoses including Multiple Sclerosis, Iron Deficiency Anemia, Dysphagia, and Muscle Weakness. Her most recent minimum data set dated 9-23-10 reflects that R4 has no assessed memory, mood, or behavioral problems. R4 is assessed as being independent with cognitive decision making abilities and is dependent on staff for most activities of daily living.

5. On 11-3-10 at 2:40 p.m. R4 related the details of incidents that she recalled occurring in August/September 2010. R4 stated concerns

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related to Registered Nurse, E12 who allegedly prevented R4 from going to bed in a timely manner, withheld medications from R4, and treated her roughly during a medical procedure.

R4 stated that E12 repeatedly "put her off from going to bed," failed to give pain "medication (neurontin) 2 or 3 times," and "scrubbed my suprapubic catheter site roughly."

R4 stated these concerns were reported to E2, Director of Nursing. E2 denied awareness of these allegations on 11-3-10 at 4:10 p.m. E2 stated that on 11-3-10 she reported these allegations to E1, Administrator. On 11-5-10 at 11:00 a.m. E1 verified that he was informed of these allegations on 11-3-10 and that the investigation was not yet complete.

E1 was questioned on 11-5-10 at 11:00 a.m. if E12 had been removed from resident contact following notification of the allegations made against her by R4. E1 stated that E12 continued to have direct contact with residents through 11-4-10. E12 was working in the facility on 11-5-10 at 5:00 p.m. without restriction.

Facility Policy titled "Abuse Policy" states "Implementation:...Investigation...If resident abuse is suspected, a licensed nurse will examine the resident for signs of injury and notify the Facility Administration, resident physician, and resident's family...the proper authorities...will be notified of the allegation....the Administrator or designee will investigate all concerns for misappropriation of resident property...Protection:...When an employee is alleged to have committed abuse of any kind, that employee shall be immediately suspended

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F9999	Continued From page 37 without pay from employment at the facility, not having any further resident contact, pending outcome of an investigation...Reporting:...All alleged incidents will be reported to the state agency and all other agencies as required..." "Addendum to Abuse Prohibition Policy" states "Under the following circumstances the Administrator shall immediately contact law enforcement authorities, the Arthur Police Department or Moultrie County Sheriff...when a crime has been committed in the facility by a person other than a resident i.e. (for example) Theft...If any resident is the recipient of any type of physical, mental, sexual, or psychological abuse or injury all steps will be taken in order to insure the safety of the resident. This includes but is not limited to:...immediate suspension of any/all staff members who are believed to have inflicted the 'act', pending completion of the investigation...." (A)	F9999		