STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G274	A. BUILDING ______ B. WING ______	04/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANN SPECIAL CARE CENTER	**109 KENWOOD ROAD CHAMPAIGN, IL 61820**

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W 331	Continued From page 34 his left side, below the knee on the bed. Area reddened, swollen and warm to touch approximately 2.0 cm in diameter and in the middle noted scabbed approximately 1.0 cm in diameter". Treatment Administration Record entry on 4/17/11 states, "area healed". In review of a Referral and Report Consultation dated 2/7/11, it states, "7 mm diameter circular ulcer pressure type. It is clean, stage II partial thickness with new epithelium around the edge". In an interview on 4/28/11 at 10:15 a.m., E2 (Director of Nursing - DON) verified that the Care Plan does not address R9's open area. E2 stated that the area on R9's left knee started as Cellulitis and then progressed to an open area. E2 stated that R9 is in constant motion rubbing his knees together.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.620a) 390.3240a) 390.3240d) 390.3240e) Section 390.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in	W9999		

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the facility. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 390.3240 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)

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 that employee. (Section 3-611 of the Act)

These Requirements were not met:

Based on record review and interview, the facility has failed to implement their policies and procedures and regulatory requirements to prevent abuse for 1 of 1 individual who alleged that a staff person had physically abused him (R3) when:

> facility staff (E's 6, 11 & 12), failed to report R3's allegations of physical abuse to the

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Administrator.
> the facility failed to report R3's 11/8/10, 11/22/10 and 1/7/11 allegations of physical abuse to the Department until 4/27/11, after the surveyor brought the allegations to the attention of the Administrator.
> the facility failed to investigate R3's allegations of physical abuse until 4/27/11.
> the facility failed to put safeguards in place to protect R3 from further abuse until 4/27/11.
> the facility failed to ensure that adequately trained staff provided abuse/neglect re-training after the 4/27/11 physical abuse allegation made by R3.

Findings include:

1. In review of R3's physician's orders, R3 functions in the severe range of mental retardation, with additional diagnoses of Bilateral Blindness, Grand Mal Seizures, Depression and Post Traumatic Stress Syndrome.

R3's 8/30/10 Inventory for Client and Agency Planning (ICAP) documents an overall age level of 1 year and 3 months. His 9/9/10 Individual Program Plan (IPP) documents that R3 has a state guardian. R3 is able to communicate verbally, can express a few of his needs and has the ability to follow simple commands with verbal prompts. R3 is non-ambulatory and requires a wheelchair for mobility.

R3's 10/27/10 (updated 3/4/11) behavior support plan documents that R3 engages in self-abusive behaviors, described as scratching his skin to the point of creating open sores. R3 will also pick and pull at his finger and toe nails to try to

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remove them. Soft mitten restraints can be utilized for 15 minutes at a time, and R3 also receives Abilify and Zoloft for behavior control.

Handwritten behavioral data sheets for R3 were reviewed.
On 11/8/10, at 6:00 a.m., it states, "I asked what happened, he said (E10) slapped (R3) in the face and didn't even take a shower."
On 11/22/10, at 6:00 a.m., it states, "(R3) said hi to me then said (E10) kicked (R3) hahaha... The 'incident' supposedly happened over the weekend."
On 1/7/11, at 7:00 a.m., it states, "(R3) said (E10) hit (R3) in the face sun (Sunday) morning."

In an interview with E11 (Habilitation Aide), on 4/28/11, at 9:17 a.m., E11 confirmed that the handwritten behavioral data sheets for 11/8/10, 11/22/10 and 1/7/11 were written by E11. E11 stated that she reported the above allegations to E12 (day training supervisor) on the same day the allegations were reported to her by R3. E11 stated that she was never further interviewed regarding any of the above allegations.

In an interview with E12 (day training supervisor), on 4/28/11 at 9:40 a.m., E12 stated she had reported the above incidents to E6 (Residential Services Director - RSD) on the same day they were reported to her. E12 stated she was never further interviewed regarding any of the above allegations.

On 4/27/11, at 2:50 p.m., E6 (RSD) was interviewed. When asked whether the allegations had been investigated, E6 stated, "I believe so...ask (E1 - Administrator/Executive

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Director)...we've all talked about this...we should get (E1) in here." E6 then left the room to get E1.

E6 returned to the room to await E1's arrival. E6 then asked, "Are you going to write down what I say?" Surveyor replied that any interview would be documented. E6 then stated, "Then I'm not talking anymore." E6 then stated, "It's not the issue it looks like on paper...In my opinion I don't believe these events happened, given (R3's) disability and history."

At 3:00 p.m., E1 (Administrator/Executive Director) and E2 (Director of Nursing - DON), entered the room. When E1 was shown the 11/8/10, 11/22/10, and 1/7/11 documented allegations, E1 (4/27/11, 3:00 p.m.) stated she had never seen this information until then, and no one had reported this information to her. E1 further confirmed that since she was not aware of the allegations, the information had not been investigated by the facility or reported to the Department, nor were safeguards to protect R3 put in place.

When asked at 3:05 p.m. on 4/27/11 with E1 and E2 present, E6 stated that he had previously read (prior to 4/27/11) the 11/8/10, 11/22/10 and 1/7/11 documents alleging physical abuse. On 5/11/11, in a 3:20 p.m. phone interview with E1 (Administrator/Executive Director), E1 stated that E10 (alleged perpetrator) has been an employee since 2/18/00. E1 further confirmed that E10 was not suspended regarding the alleged abuse until 4/27/11.

On 4/27/11 at 3:35 p.m., E1 (Administrator)

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stated to both surveyors that the facility was in the process of re-training staff in abuse/neglect policy and procedures. E1 further stated that E6 would be putting the training together and providing the training. When surveyors questioned E1 regarding why E6 (who was aware of the allegations, but did not report the allegations to E1/Administrator), was implementing the staff training, E1 stated that E6 would not be providing the staff training.

The facility's 08/09 "Policy and Procedure for Prevention of Abuse, Neglect, and Theft" was reviewed. Per the policy, it states, "Swann Special Care Center does not and will not condone resident abuse, neglect, or theft of resident or staff property, by anyone, including staff members...."

"You, as an employee of Swann Special Care Center, are responsible to report any suspected incident...Staff must report any allegations of abuse, mistreatment...to their Supervisor or the person in charge immediately...If abuse, neglect or theft is alleged or suspected, the employee is to be immediately suspended pending the results of the investigation and the Executive Director is to be notified immediately...The Illinois Department of Public Health must be notified by the facility of an allegation of abuse, neglect, theft or significant injuries within 24 hours...the results of the completed investigation shall be forwarded to the Illinois Department of Pubic Health within five (5) working days of the allegation."

(A)