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	145847	A. BUILDING _____ B. WING _____	C 08/07/2012

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F 226	Continued From page 21	F 226		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240b) 300.3240d) 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)	F9999		

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F9999	Continued From page 22	F9999		

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)

These requirements were not met as evidenced by:

Based on record review and interview, the facility failed to operationalize the facility's abuse policy by failing to report an allegation of abuse to the administrator immediately, allowing a Certified Nursing Assistant to have direct contact with residents after a potential abuse incident, delaying the initial investigation of potential abuse and to thoroughly investigate injuries of unknown origin. This had the potential to affect all of the 89 residents living in the facility.

Findings include:

1. The facility's Abuse Prevention Policy, not dated, documented "1. Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation. 2. The Administrator must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator must be called at home or must be paged and informed of such incident." The Policy's Investigation Section documented "The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the

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F9999	Continued From page 23	F9999		

investigation.

2. On 8/1/12 at 10:25 AM, an interview was conducted with E16, Certified Nurse's Assistant (CNA). E16 stated in March 2012 she was assisting E13 (CNA) with transferring R3 into a shower chair. E16 stated R3 was calm but was repeating herself. E16 stated E13 told R3 to "shut the fu-- up" and called R3 a "bi---." E16 stated while E13 was saying these things to R3 she was poking R3 in the forehead. E16 stated she did not report this incident to any facility staff after this incident occurred. E16 stated in May 2012 she reported the incident which occurred between E13 and R3 to E11, Licensed Practical Nurse (LPN). E16 stated E11 encouraged her (E16) to report the incident to E1, Administrator, and E2, Director of Nurses (DON). E16 stated she did not report this incident to E1 or E2.

On 8/1/12 at 9:00 AM, an interview was conducted with E17 (CNA). E17 stated a few months prior, she and E18 (CNA) were standing at the nurse's station and overheard a CNA tell E11 that E13 pushed another resident in the forehead and call this resident a "bi---." E17 stated she and E18 reported this allegation to E19, Human Resource Director (HRD), immediately. E17 stated she and E18 went to E2's office and reported the allegation to E2. E2 told them the allegation could not be investigated because it was hearsay. E17 stated "We got very mad because we are told at every meeting to report any allegation of abuse but when we did, she wouldn't investigate it."

On 8/1/12, at 9:55 AM, an interview was conducted with E11 (LPN). E11 confirmed that in

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F9999	Continued From page 24	F9999		

May 2012, E16 reported to her that E13 called R3 and bitch and was poking R3 in the middle of her head. E11 stated she told E16 to report the incident to E1 and E2. E11 stated she did not personally report this allegation to E1 and E2. E11 stated she was aware E16 did not report the allegation but stated E17 and E18 (CNAs) reported the allegation to E19, HRD.

On 8/1/12 at 12:05 PM, an interview was conducted with E1. E1 stated he was not aware of the above allegation of abuse until today (8/1/12).

The facility failed to immediately report an allegation of abuse to E1 which delayed the investigation of the allegation. This allowed E13 to have direct contact with R3 after the alleged incident in March 2012 occurred.

3. R3's Resident Incident Report dated 5/19/12 at 10:00 AM documented "Called to shower room by (E8), CNA. Resident noted to have large purple bruise from left wrist to left elbow. Resident questioned and doesn't recall what happened."

E5's (LPN) Statement, dated 5/19/12, documented "This writer was called to shower room by (E8), CNA. Resident noted have a large oval shaped bruise to her R (Right) forearm that goes from her wrist to elbow. Underside of (R) forearm free of bruising. It appears that resident bumped her arm on a hard object due to shape of bruising. No apparent finger marks noted." E5's Statement documented "When questioned, resident was not aware she had a bruise & was unaware how it happened."

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F9999	Continued From page 25	F9999		

On 7/27/12 at 3:30 PM, an interview was conducted with E5. She stated R3 had a significant bruise from her left wrist to her left elbow purplish/red in color. E5 stated "It covered her entire forearm area. It was significant."

The facility's Investigation for this incident was reviewed. The only statements obtained regarding R3's bruise were written by E5 (LPN) and E20 (LPN). The facility did not conduct a thorough investigation by obtaining statements from all direct care staff who had cared for R3 around the time her bruise was discovered. On 7/27/12, at 9:50 AM, an interview was conducted with E1. E1 stated the Department was not notified of this allegation.

On 8/2/12, at 3:30 PM, an interview was conducted with E1. E1 stated the only statements obtained regarding this incident were from E5 and E20.

4. R3's Resident Incident Report dated 7/23/12 at 3:00 PM documented "(E6, Certified Nurse's Aide, CNA) wheeled resident down from hallway into dining room when bruise was noticed by (E7, Memory Unit Manager), and E6, CNA."

E6's statement dated 7/23/12 documented "As I brought (R3) into the dining room (E7) and myself noticed a bruise on her forehead, when I asked her what happened she said 'someone hit me.' I asked who hit her and she said 'I don't know.' About 30 minutes later I asked again what happened to her head, she replied 'Don't worry about it it'll go away.' I told her I needed to know but she kept saying 'It'll go away.'"

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F9999	Continued From page 26	F9999		

On 7/26/12 at 3:30 PM, E7 was interviewed. E7 confirmed she noticed the bruise on R3's forehead around 2:15 PM on 7/23/12. E7 stated she asked R3 multiple times how she sustained the bruise and R3 did not know. E7 stated she contacted E13 because E13 had taken care of her earlier that day. E7 stated E13 said she noticed the bruise on R3's forehead and forgot to tell the nurse.

E4, Registered Nurse's (RN) statement dated 7/23/12 documented "On 7/23/12, I came to work on the Memory Unit. I noticed that (R3) had a half-dollar size bruise to her forehead. (E6 and E7) noticed as well and was reported to day shift nurse right before change over. I asked how it happened and no one knew. (E7) called (R3's) day shift CNA to find out if she knew. She called (E13) and (E13) stated she did notice it in shower, she put ice on bruise and failed to report it to (E5, Licensed Practical Nurse, LPN). (E5) stated that she didn't notice the bruise during day shift." E4's statement did not document that R3 had initially reported to staff she was hit by someone.

On 7/27/12 at 3:30 PM, E5 was interviewed. E5 stated on 7/23/12 at around shift change E7 came to her and asked if she knew anything about the bruise on R3's forehead. E5 stated she was not aware of the bruise. E5 stated E13 was R3's CNA that day. E5 stated E13 did not report she had discovered a bruise on R3's forehead.

R3's Incident Report Form - IDPH (Illinois Department of Public Health) Notification, dated 7/24/12 at 8:30 PM documented "Resident (R3)

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F9999	Continued From page 27	F9999		

identified with a bruise yesterday, investigation started. Resident initially stated she didn't know how it happened. Today resident alleged someone hit her. Investigation to continue. Administrator immediately notified."

E3 (LPN) on 7/24/12 at 8:40 PM documented in R3's nurse's note "This evening at approximately 7:30 PM I interviewed the resident concerning the bruise on her forehead. Initially the resident stated she did not know how it occurred. I asked once again and the resident stated that someone who worked here had hit her. There resident stated that they were a white female with black hair."

On 7/27/12 at 2:50 PM, an interview was conducted with E3. E3 stated the evening of 7/24/12, E9 (CNA) reported R3 alleged she had been hit.

On 7/26/12, at 3:00 PM, an interview was conducted with E9, CNA. E9 stated on 7/24/12 after dinner, she and E10, CNA were documenting in the hallway and E10 noticed the bruise on R3's forehead. E9 stated "I asked (R3) to come over and then asked her what happened to her forehead. (R3) said 'Nobody hurt me and put her head down.'" E9 stated she again asked R3 what happened to her forehead and R3 responded "She hit me." When asked if she (E9) had given a statement to E1 regarding this incident, E9 stated "No, they didn't ask me or (E10) to give a statement."

On 7/27/12 at 11:05 AM an interview was conducted with E13. E13 stated she gave R3 a shower around 9:00AM-10:00 AM. She stated "I

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F9999	Continued From page 28 noticed some small bruises on her arms and a purple one on her forehead." When asked if she reported R3's bruise to the nurse, E13 stated "I usually put them on my shower sheet but I didn't. She has a lot of bruising." The facility's final investigation regarding this incident was reviewed. E13 failed to report R3's bruise of unknown origin. The facility failed to immediately report to E1 and investigate R3's initial allegation of abuse which was reported to E6 on 7/23/12. Statements obtained through investigation were reviewed. The facility only interviewed and obtained statements from staff who observed R3's bruise. The facility did not conduct a thorough investigation by obtaining statements from all direct care staff who had cared for R3 around the time her bruise was discovered to determine the cause of the bruise. 5. The Facility Data Sheet, dated 7/26/12 documents that the facility has 89 residents living in the facility. (A)	F9999		