STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145456	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CARLINVILLE	1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1220b)3) 300.3240a) 300.3240b) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	F9999		

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F9999	Continued From page 35 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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) These requirements are not met as evidenced by: Based on interview, observations and record review, the facility failed to prevent verbal abuse and involuntary seclusion for 1 of 4 residents (R25) reviewed for abuse investigations in the	F9999		

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supplemental sample. This failure resulted in R25 being verbally abused and place in involuntary seclusion.

Findings include:

1. According to the Minimum Data Set (MDS) dated 12/19/11, R25 is an 84 year old male admitted to the facility on 6/24/11 with diagnosis of Dementia. The MDS identifies R25 as having short/long term memory deficits with cognitive impairment and is independent in ambulation. Mood/Behaviors also indicates he has feelings of being down, depressed or hopeless on half or more of the days. R25 resides on the closed Dementia unit.

An Abuse Allegation Summary/Worksheet dated 1/26/12 documents 2 (E16 and E17) Certified Nurses Aides (CNA) overheard E15, CNA tell R25 to "get his a-- back to his room because" she was "tired of dealing with him." The allegation also alleged that a sit to standing device was moved in front of his bedroom door so he "couldn't leave his room."
The worksheet does not identify when the incident occurred but indicates it was reported at 10:25am on 1/26/12. The list of evidence documents that the accusations also included seeing a "sit to stand parked in front of room while resident was in room. Staff heard (E15) raise her voice to R25 to go back to room."

Interviews conducted during the investigation by E1, Administrator on 1/26/12 with E16 and E17 indicated that E16 stated E15 told R25 to back to his room and take his "a-- back to his room because she is tired of dealing with him. She

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(E15) also parks the sit to stand in front of his room door to block him in his room." E17 documented at 1330 (1:30pm) "E15 told R25 to keep his a-- in his room. I have seen her put her fingers in his face and say "you are annoying the s--t out of me." Both were signed by the CNAs and Administrator, E1. Additional statement from E19, CNA on 1/26/12 documents "E15 stated to CNA that she was tired of his bulls--t and following her around getting on her nerves" and when asked about the sit to stand blocking his doorway, wrote "yes, same day as CNA stated was tired of him."

On 1/27/12 at 10:45am, E20, CNA wrote she heard comments by E15 for R25 to get back to his room as she is tired of dealing with him also documenting that "her tone was raised." When asked about the sit to stand, E20 stated "Yes, I don't know if the wheels were locked on the sit to stand. I was relieving E15 on break. R25 was in his room walking around. I moved the sit to stand away from his doorway."

A statement by E15 on 1/30/12 at 11:00am documents that when asked about raising her voice at R25, E15 wrote "I have because there was water or something on the floor. He wasn't listening so I did raise by voice to keep him from slipping when he opens other resident's door I tell he him can't come in and he says 'Huh' so I raise my voice so he can hear me. When asked about blocking his door, E15 reported that she had, there was a puddle of urine on the floor and he would stay out of the area so I could clean it up so he wouldn't fall or slip in it." Written statements gathered by the facility from both E16 and E17 fail to include observations of puddles

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F9999	Continued From page 38 under the sit to stand in the doorway. In interview on 5/17/12 at 1:15pm, E16 CNA stated she observed the incident between E15 and R25 the day before she reported it and you could really tell that E15 was aggravated by R25 that morning. The incident occurred at change of shift as they were coming down the hall and E15 was leaving. E16 stated she observed E15 put her finger in his face and state "get your a-- back in your room." At 1:37pm, E16 also observed the sit to stand parked in front of R25's door that prevented him from coming out of his room which she considered a "restraint." E16 identified the behavior observed as "abusive" and stated that was why she reported it. On 5/17/12 at 2:10pm, E17 stated she heard and saw E15 point her finger in R25's face and say "get your a-- back in your room, I'm sick of looking at you." E17 also confirmed that the sit to stand placed earlier by E15 was blocking R25's doorway preventing him from coming out of his room. E17 did not note a puddle being present underneath it. E17 identified the behavior she observed from E15 toward R25 was abusive and that it included preventing him from coming out of his room. On 5/15/12 at 10:00am, R25 was observed to be ambulating independently in the hallway of the unit and continued to do so throughout the survey. R25 was also observed to follow staff up and down the hallway during the day. On 5/17/12 at 2:20pm, E20, CNA stated E15 told her on midnight shift that she got tired of R25 following her up and down the hall and had noted	F9999		

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the sit to stand parked in front of his doorway. She stated she told R15 that she could not do that and removed the sit to stand from the doorway. E25 stated she has overheard E15 talking to others roughly too but was unable to provide names and times as she only works midnights occasionally. E20 stated she would agree that it was abusive behavior and did not understand why E15 was left on the dementia hall after the incident occurred with R25. When asked if she had reported any of the incidents she observed, stated no but others had.

The facility's POLICY AND PROCEDURE regarding Abuse and neglect, Involuntary seclusion, documents that all residents have the right to be free of from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The policy's definition of VERBAL ABUSE is "means the use by an employee or agent of oral, written or gestured language that includes disparaging and derogatory terms to a resident or within his or her hearing or seeing distance, regardless of the resident's age, ability to comprehend or disability. The definition of Involuntary seclusion means "Separation of a resident form other residents or from his or her room or confinement to his or her room (with or without room mates) against the resident's will, or the will of the resident's legal representative."

On 5/17/12 at 1:00pm in interview, E1 Administrator was asked why he would determine that the incident was not abusive when it fit the facility's definition. He stated there was animosity between E15 and E20 but agreed that the allegations and observations were actually made

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F9999	Continued From page 40 by E16 and E17. E1 agreed that the alleged incident occurred on the morning of 1/25/12 and not on 1/26/12 and confirmed that E15 was overheard by E16 and E17 but E15 denied it. E1 stated E15 had left the morning of the incident following her shift and was suspended pending the investigation on 1/26/12. E1 stated she returned to work and worked on the same dementia unit until just a few weeks ago. E1 stated E15 was not inserviced and/or disciplined in regards to the incident on 1/25/12. On 5/31/12, at 1:20pm, E1 stated that E15 requested to be transferred to the evening shift. He could not give an exact date. E15 was put on the schedule to work the evening shift and was scheduled for all halls in the facility starting 3/25/12. The staffing sheet documents E15 worked on the dementia unit 5/20, 5/23,5/27, 5/29 and 5/30/12. Review of R25's care plan on 5/30/12 fails to include any information reflecting that R25 is at risk for abuse due to his wandering and following behaviors. (A)	F9999		