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F 490	Continued From page 29 4. On 2/28/13 the Abuse Prevention and Prohibition policy was revised by E2. 5. On 3/6/13 at 12:30 PM E1 and E2 verbalized an understanding of and demonstrated competency with regard to Abuse Prevention regulations and facility operating policies. 6. On 3/6/13 at 1:30 PM all staff were trained on the new Abuse Prevention and Prohibition policy, the revision in the "Feeding Residents" policy and the revisions to the "Administering Medications" to residents policy. This was completed by E2. 7. Quality Assurance (QA) Committee will monitor and oversee the abuse allegations and investigation. The QA committee will review all allegations of abuse at the quarterly meeting for proper implementation, recognition of abuse and management of the investigation. Designated member of the Board of Directors will oversee the Abuse QA by receiving a report of the discussion at the quarterly meeting. The Designated member of the Board of Directors will also review each allegation of abuse, received monthly for proper implementation.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240d) 300.3240e)	F9999		

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F9999	Continued From page 30 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall	F9999		

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immediately report the matter to the facility administrator.

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.

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.

This requirement was not met as evidenced by:

Based on interviews and record review the facility staff failed to ensure that R1 and R2 were not mistreated in accordance with facility policy. Witnessed mistreatment of R1 consisted of R1 being jerked up in bed, yelled at, forced to eat food when R1 stated she was not hungry and refused to eat. Witnessed mistreatment of R2 consisted of R2's head being restrained by the nurse and forced to swallow medications. This resulted in R2 becoming very upset, flinging her arms and screaming at the nurse and other attending staff. Neither incident was recognized as mistreatment by the facility's Abuse Prevention Coordinator, the Administrator. The facility failed to recognize two incidents as allegations of abuse, failed to protect residents from alleged perpetrators, failed to investigate and failed to

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F9999	Continued From page 32 report allegations of abuse involving R1and R2 immediately to the Administrator. The facility also failed to report the allegations of mistreatment to the state survey and certification agency for R1and R2. The facility's Administrator, designated as facility Abuse Prohibition Coordinator failed to operationalize all components of the facility's abuse policy by not recognizing two witness accounts of alleged abuse for R1 and R2, failing to report the two allegations of abuse to the State Survey and Certification Agency, failing to protect R1 and R2 from the alleged perpetrators and failing to investigate the two witnessed accounts of alleged abuse for R1 and R2. The Administrator failed to ensure the safety and well being of all residents. Staff delayed 3 days before reporting a witnessed allegation of abuse involving R1 to the Administrator. The Administrator demonstrated poor working knowledge of the facility's abuse prevention policies, regulations related to abuse prevention, and the necessity to remove alleged perpetrators pending an investigation. The Administrator demonstrated poor judgement and questionable ability with regard to performing an investigation of reported witnessed mistreatment. R1and R2 are two residents reviewed for abuse in a sample of three. These failures have the potential to affect all 71 residents. Findings include: 1. The Physician's Order Sheet (POS) dated February 2013 for R2 lists the following diagnoses: Altered Mental Status, Moderate Dementia with Psychotic Behaviors and Early	F9999		

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Alzheimer's Disease. The Minimum Data Sheet (MDS) dated 11/13/12 states R2 is severely cognitively impaired, has unclear speech and only responds adequately to simple, direct communication. R2 requires extensive assistance with two staff for bed mobility, transfers and toileting. R2 was not able to be interviewed due to her cognitive impairment.

On 2/21/13 at 12:06 PM E14, Activity Aide stated to IDPH (Illinois Department of Public Health) Surveyor that she had reported an allegation of mistreatment of R2 on 12/28/12 to E15, LPN (Licensed Practical Nurse) and E1, Administrator / Abuse Prevention Coordinator and nothing was done about the allegation. E15 stated on 2/21/13 at 12:38 PM she reported this allegation of mistreatment of R2 to E1 the day the incident happened after it was reported to her by E14 and E17. E14 stated that she witnessed E16, RN (Registered Nurse) come into the D Wing without announcing herself and went behind R2's wheelchair and wrapped her arm around R2's chest. E16 grabbed R2's chin tilted R2's head back, held R2's head, and told R2 she had to take her medicine and poured the medicine into R2's mouth. E14 stated that E17, CNA also witnessed E16 doing this to R2 and reported this to E15. E14 stated that E16 was rough with R2 during this incident.

E15 stated on 2/21/13 at 12:38 PM that E14 and E17 did report the allegation of R2 being mistreated by R16 to her. E15 stated the two CNAs were upset and stated E16 was very rough with R2 when giving R2 her medication. E15

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stated she reported the allegation to E1 right after the two CNAs reported this information to her. E15 stated she told E1 how upset E14 and E17 were about the mistreatment of R2 being handled roughly by E16 during medication pass.

E1 confirmed on 2/21/13 at 1:30 PM that E14 and E15 reported the incident to her about E16 giving medications to R2 . E1 stated in that same interview that E1 did not investigate the incident as mistreatment of R2 and did not report the incident to IDPH. E1 stated that "she did not believe it was abuse, just inappropriate way of giving medications." E1 stated that R16 had been a hospital nurse for years and they did things differently in the hospital. E1 explained that E16 did not have the knowledge in giving R2 her medications properly because R2 is a difficult resident to give medications to and R2's medication had to be placed in her milk for R2 to drink.

On 2/27/13 at 12:55 PM E17, CNA (Certified Nurse Assistant) stated, "I was in the day room passing trays when (E16) came down to D wing. (E16) just came through to the front of the dayroom area, went up to (R2) and stated 'I have your medicine.' then put a hand to the side of her face and was trying to force the spoon into (R2's) mouth. (R2) had her mouth clamped. (E16) was holding (R2's) head still and (R2) finally did get the spoon of medication into her mouth. (R2) was very angry and was making noises, (R2) started flinging her arms at (E16), when (E16) walked away from (R2) myself and another CNA (E18) tried calming (R2) down. (R2) was having

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no part of that and R2 was still angry and making noises at us. (E17 and E18). (E16) the nurse just walked out of D wing, did not check on (R2) at all. I reported this to the nurse (E15) right after the incident happened. I seen this as abuse to (R2)."

E18, CNA stated on 2/27/13 at 12:19 PM "It was me and (E17) working that day, ...(E16) made (R2) drink the shake she had her medications in. (E16) was a little rough to (R2) trying to make (R2) drink and held her head. (E16) held(R2's) head back to put the drink into (R2's) mouth. I don't think this was appropriate, (E16) could of asked one of us how (R2) takes her medications but(E16) did not ask. (R2) threw a fit at first , flinging her arms about and screaming. I did not report this to the nurse because (E17) reported it to (E15).

R2's Care Plan dated 2/7/13 states under "Problems" " I (R2) have a hearing deficit and do not always speak clearly. I(R2) also have dementia which can make my communication ability impaired." The Intervention section states "....... I (R2) did live on a small special dementia unit with consistent caregivers. They are able to understand me(R2) better because of the familiarity. If you have trouble understanding me, ask them for assistance."

E16 was never removed from direct resident care following receipt of the alleged mistreatment of R2 that occurred on 12/28/12. The facility's daily and monthly time schedules document that E16 was scheduled and worked her designated dates

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F9999	Continued From page 36 as a Registered Nurse from 12/28/12 to 2/21/13. E16 had access to all the residents within the facility. On 2/28/13 at 10:55 AM E1 confirmed that E16 had access to all residents and continued to work in the facility as a Registered Nurse from 12/28/12 to 2/21/13. 2. The Physician's Order Sheet (POS) dated February 2013 lists the following diagnoses for R1: Hyperkalemia, Congestive Heart Failure, Dementia and Tremor with Cerebellar Ataxia. The Minimum Data Set (MDS) dated 2/20/13 states R1 to be moderately impaired in making decisions regarding tasks of daily life, R1's decisions are poor and requires cues and supervision by staff. R1 has difficulty focusing attention and was not able to be interviewed due to being cognitively impaired. R1 requires extensive assistance of two staff for toileting and ambulation. R1 also requires setup help only for meals and is able to feed self without assistance of staff. R1's Nurses Notes dated 1/21/13 at 3 PM documents that R1 returned from the doctor's office with an order to be placed on Tamiflu and respiratory isolation for five days. Temperature 100 degrees. R1's Nurses Notes dated 1/21/13 to 1/27/13 describes R1 as being weak, not willing to get out of bed, having a non productive cough, refusing to eat or drink and unable to perform activities of daily living with assistance from the staff. Nurses Notes on 1/28/13 at 12:30 PM states " Updated physician on patient's condition. No temperature, still coughing , refusing to eat."	F9999		

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E10, CNA documented on an untitled sheet of paper given to E1,Administrator/Abuse Coordinator on 1/30/13 that she witnessed E3, LPN on 1/28/13 at R1's bed jerking R1 up by the neck from a lying position. The document stated that E3 was trying to force R1 to eat and was yelling at her that R1 had to eat. R1 was repeatedly stating to E3 that she did not want to eat. On 2/13/13 at 10:59 AM E10 confirmed that she did document the incident and placed it in E1's mailbox. E1 confirmed on 2/21/13 at 10:48 a.m. that E10 did document the incident on paper and placed it in E1's mailbox and E1 did not retrieve the paper from her mailbox until the following week. E1 stated in the same interview that she could not give an answer as to why she did not do anything about the incident when she finally found the document that E10 had written.

E10 stated on 2/13/13 at 10:59 AM she had witnessed E3 on 1/28/13 jerking R1 up by the neck and was forcing R1 to eat. E10 stated E3 was trying to put food into R1's mouth and R1 kept moving her head and stating she did not want to eat. E10 stated E3 was yelling at her to eat. E10 stated that she did not report the incident until 1/30/13 because bed alarms were going off and she had no help or time.

E10 stated on 2/13/13 at 10:59 AM that E10 first reported the incident to E12, CNA Supervisor on 1/30/13 and E12 stated "I don't believe (E3) would do anything like that. She is not that type of nurse." E12 failed to report the incident to E1. On

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F9999	Continued From page 38 2/21/13 at 11:04 E12 stated she did not remember E10 reporting anything to her about the incident with E3 and R1. E12 stated she was off the next two days after E10 stated she reported the allegation to her. E12 stated she was not saying that E10 didn't report to her but E12 stated she could not remember. E10 stated that E12 did not report the allegation to E1, so E10 reported the incident to E11, RN and E13, LPN. E10 continued to state that E11 called E1 and reported the allegation to E1. E10 stated E11 gave her the phone and E10 also gave all the details to E1 about the allegation of mistreatment of R1 by E3. E10 stated that E1 asked her to write the incident up and place it in her mailbox. On 2/21/13 at 9:51 AM, E11 confirmed that E10 reported to her the allegation of mistreatment of R1 by E3 on 1/30/13. E11 confirmed she called E1 and reported the allegation to E1. E11 stated she witnessed E10 write the incident on a piece of paper and placed it in E1's mailbox on 1/30/13. On 2/21/13 at 10:11 AM E13, LPN confirmed she was present when E11 called E1 and reported the allegation of mistreatment to E1. On 2/21/13 at 10:48 AM E1, confirmed that on 1/30/13 she received a phone call from E11 stating E10 saw E3 jerk R1 up by the neck and tried to force R1 to eat. E1 also confirmed that she spoke with E10 and asked her to write the incident up and place into her mailbox. E1 stated that she did not do anything about the incident	F9999		

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until IDPH (Illinois Department of Public Health) Surveyor entered the building on 2/6/13. E1 stated "I can't give you an answer why I did not do anything about the allegation." E1 confirmed she failed to report this allegation of alleged abuse to IDPH until 2/6/13.

On 2/27/13 at 2:30 PM E1 stated "I did not see this incident as abuse". E1 confirmed on 2/27/13 at 2:30 PM that E1 did not report either incident of abuse for R1 and R2 to the state survey agency, did not investigate or suspend alleged perpetrators E3 or E16 when the allegations of abuse were reported to her. E1 stated on 2/28/13 at 10:55 AM that both employees E3 and E16 had continued access to all 71 residents in the building. The Illinois Department of Public Health form titled "Facility Data Sheet" list the facility census at 71 residents residing in the facility.

E3's time cards document that E3 continued to have unrestricted access and worked as a Licensed Practical Nurse for the facility on 1/28/13, 2/1/13, 2/4/13 and 2/6/13. E3's employment was terminated by E1 on 2/6/13 for the mistreatment of R1 on 1/28/13.

The facility's undated Abuse, Prevention and Prohibition policy states "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including , but not limited to facility staff, other residents....or other individuals. The policy continues to state: "The facility prohibits mistreatment, neglect or abuse of

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F9999	Continued From page 40 residents.. This also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being...." The Abuse Policy states under section II "Training": "Facility staff shall be trained on the abuse prohibition program during orientation and ongoing during educational sessions..." The facility's form titled "Abuse Policy Acknowledgement" was signed by E16, on 11/13/12 and E3 signed the form on 4/19/12. The form has an acknowledgment at the bottom stating "This will certify that a copy of facility Abuse Policy was given to the person who signed the above receipt and that training was provided to the contents. It is confirmed that this person understands the policy." An additional inservice on Abuse Prohibition was held on 12/18/12 at 1:30 PM. There is no documented evidence that either employee, E16 or E3 attended this inservice training, their signatures are not on the sign in sheet. (A)	F9999		