

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2013
NAME OF PROVIDER OR SUPPLIER ROCHELLE GARDENS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1021 CARON ROAD ROCHELLE, IL 61068		
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F9999 F9999	Continued From page 46 FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.3240e) 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	F9999 F9999			

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F9999	<p>Continued From page 47</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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 3-611 of the Act)</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to keep residents from being verbally, mentally and/or physically abused by E6. This failure resulted in R48 becoming upset after being yelled at and treated rudely.</p> <p>This is for 3 residents (R22, R45, R48) reviewed for abuse and neglect.</p>	F9999			

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F9999	<p>Continued From page 48</p> <p>The findings include:</p> <p>1. A grievance/complaint report was submitted by R48 on 1/28/13. In the report, R48 documents returning to the facility after a trip (out to eat, get a hair cut and look at medical id bracelets) with another resident on 1/26/13. R48 stated, "We returned on time but E6(Licensed Practical Nurse - LPN) ripped into me. He asked if he could talk to me in private away from [another resident]. [The other resident] left. E6 spoke to me loudly at my room door. He did not enter and make it private, but chose to let the whole hallway hear if they wanted to listen. He asked why I didn't wear my mask in public and how I was contaminating my world. He let me know that MRSA (Methicillin-resistant Staphylococcus aureus) was serious. At [previous facility] MRSA meant isolated rooms and laundry. Residents walked around and ate with everyone else as normal. He called me stupid. That wasn't good enough, I was completely ignorant. I didn't reply much but stated I would do better wearing my mask. I am an educated person but not in medical science. If it was so detrimental, why didn't they approach the issue earlier. I felt awkward, confused, bad, stupid, ignorant and sad. Good job E6, I sure wouldn't treat anyone that way. It makes me tear up just to write this down. It would be hard for me [R48] to open up with my feelings since I feel hurt by a bully."</p> <p>On 6/19/13 at 8:55am, E2 said "E6 raised his voice and R48 took it as he was "coming at her".</p> <p>On 6/19/13 at 2:45pm E1 (Administrator) said, "In this case, I did not interview anyone else. It wasn't abuse, just customer service."</p>	F9999			

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F9999	<p>Continued From page 49</p> <p>The facility's incident investigation form dated 2/19/13 at 1pm documents, "Resident [R48] had issue with male nurse E6. Investigation showed resident was person using inappropriate words to nurse, not nurse to resident."</p> <p>There was no summary of the investigation to describe the "issue" R48 had with E6. There was no documentation of interviews with E6, other staff or residents.</p> <p>The nurse's notes dated 1/28/13 at 10am document, R48 is alert and oriented x 3. The MDS of 5/9/13 assessed R48 as cognitively intact with no memory problems.</p> <p>The facility ' s Abuse Prevention Program (11/11/11) showed, " Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation; Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability; Physical abuse includes hitting, slapping, pinching, and controlling behavior through corporal punishment.</p> <p>2. A note written by E22 (Registered Nurse - RN) (no date) showed, "While I was giving R45 her medications, she told me that yesterday E6 (Licensed Practical Nurse - LPN) shook her by her shoulders and told her to "shut up" and stop pulling the call light. I notified E2 (Director of Nursing - DON) and E1 (Administrator) at 6:30pm on 1/31/13."</p> <p>The facility's "First and Final Report " dated 2/3/13 showed, "Date Incident Reported: 1/31/13 at 7:00pm; Type of Incident: Alleged physical abuse onto a resident; Resident: R45. Resident's</p>	F9999			

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F9999	<p>Continued From page 50</p> <p>Diagnosis: Anxiety State Unspecified. Incident: On 1/31/13, R45 reported to a nurse that a nurse shook her shoulder on 1/30/13 during medication pass.; Conclusion: The abuse allegation against E22 is not valid. "</p> <p>The Abuse/Neglect Incident Investigation Form dated 2/1/13 showed, "On 1/30/13 at 7:00pm I entered the room of R45. She was awake and yelling for medication. I gave R45 her pills and eye drops."</p> <p>On 6/18/13 at 12:15pm, E8 (Assistant Director of Nursing - ADON) stated she would be able to tell if a staff member was abusing a resident by, "Bruises, skin issues and a change in resident behavior but we have residents that have behaviors." E8 stated she would remove staff from the building immediately if another staff member told her that a staff member was abusing a resident.</p> <p>On 6/18/13 at 3:00pm, E6 (Licensed Practical Nurse - LPN) was interviewed about abuse and stated a resident would "speak out, verbalize" if a staff member was abusing a resident. E6 stated if staff is accused of abusing a resident the staff is removed from the floor, sent home and an investigation is done; A body check is done and witnesses are interviewed.</p> <p>3. The facility's "Alleged physical abuse investigation" dated 6/4/13 showed, "R22 stated that E6 (LPN) had thrown him into his bed in the early morning of 6/4/13. E6 sequestered in nursing station office until investigation is completed. "</p> <p>On 6/19/13 at 8:50am, E2 (Director of Nursing - DON) stated, "There was an allegation of abuse 2-3 weeks ago against E6. R22, out of the blue, came up the hall and said, "You (E6) are the one that threw me down in bed last night." They (E1 -</p>	F9999			

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F9999	<p>Continued From page 51</p> <p>Adminstrator, E8 - Assistant Director of Nursing & E4 - Social Services) asked E6 to stay off that hallway and away from R22. E6 was not sent home he stayed and worked."</p> <p>The Abuse/Neglect Incident Investigation Form dated 6/4/13 at 5:05pm, written by E23 (Certified Nursing Assistant - CNA) showed, "R22 told the administrator along with E23 (Certified Nursing Assistant - CNA) that E6 threw him into bed around 4:00am on 6/4/13. R22 just decided to report it late. " The Abuse/Neglect Incident Investigation Form dated 6/4/13 at 5:05pm showed R22 was asked why he reported it so late ? R22 stated, "I have no answer."</p> <p>The facility's Resident Interview form dated 6/4/13 at 5:05 pm, written by E1 (Administrator) regarding R22 showed, "A nurse pushed me into bed and cussed at me. He has a beard. He pushed me into my bed this morning." R22 pointed to E6 as the nurse that was involved. R22's Incident Investigation form for Abuse/Neglect dated 6/4/13 at 5:10pm showed "re-interview" at the top of the form and R22 stated, "All staff are treating me well but E6."</p> <p>The Psychiatric Follow - Up Evaluation form dated 5/29/13 for R22 showed, "No aggression, agitation or hallucinations. R22 said he is dealing with his Leukemia diagnosis and will not be going through treatment."</p> <p>The Care Plan dated 6/6/13 for R22 showed, "R22 is known/has history of displaying inappropriate behavior and/or resisting care/services; agitated with family related to nursing home placement."</p> <p>The Nurse's Notes dated 6/10/13 for R22 showed, "Ecchymosis to right lower arm noted 3.5 x 6.5cm. R22 was not aware of the bruising and can't recall a time of occurrence."</p>	F9999			

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F9999	Continued From page 52 4. Confidential interviews were conducted while on site during the survey between 6/17/13 - 6/19/13. Resident comments regarding staff treatment included the following statements: 1. We have no input what so ever, (regarding changes) they just tell us the way it is. 2. Weekend and night staff have a different routine from day shift. It's a skeleton crew. 3. E6 (LPN) has a cold manner, with no resident rapport. 4. E6 is not accessible, he likes to hide, we have to find him, often in the therapy room. 5. E6 likes to goof off and rough house with nurses. 6. If I ask for medications, he always tells me it's not time yet. 7. I missed 14 of my 28 doses of my medication during the evening shift because I was afraid to ask for it. I don't want to tick him off, he does not like to be told by a resident. 8. E6 sets up the medications at the cart, and tells the residents it is their responsibility to get their own meds. 9. He responds in a sharp, snap, bark voice when you ask for something. 10. They give showers (to residents) whenever they want to, even during the night. They wake residents up and take them into the shower room. 11. E6 made a scene last night (in my room) he talked very loud with a disgusted with you attitude. 12. E6 has been known to go off before. I have heard him in the lunch room, busts out in a loud voice. He stated, "If they pick on us, we can pick on them." 13. Heard E6 tell a resident "I will force you to return to your room". (B)	F9999			

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F9999	Continued From page 53 300.1030d) Section 300.1030 Medical Emergencies d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure at least 2 staff on duty were certified in Cardiopulmonary Resuscitation (CPR). This applies to all 54 residents in the facility. The finding include: On 6/19/13 the facility presented a list of all staff currently employed by the facility that shows 9 (CNAs (2 days shift, 3 PM shift and 4 night shift), 1 LPN (Day shift) and 6 RNs (1 Day shift, 4 PM shift, 1 nights shift and E8 (ADON)) are certified in CPR. Review of the facility nursing/CNA schedule for June 2013 shows that there was only 1 staff member certified in CPR working on the day shift on June 1, 2, 8, 9, 15 and 16 and on the night	F9999			

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F9999	Continued From page 54 shift on June 1, 4, 9 and 14. On 6/19/13 at 8:30 AM, E2 (DON) stated that she is certified in CPR, however she and E8 (ADON) do not work on the weekends (June 1,2,8,9,15,16). Review of the staff CPR cards presented by the facility on 6/19/13 shows that 1 RN (E3-Day shift) and 1 CNA (E20-Night shift) CPR Certification have expired. <p style="text-align: center;">(B)</p>	F9999			