STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010052	A. BUILDING: _____ B. WING _____	C 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER HOUSE	1125 NORTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.3240a) 300.3240c) 300.3240d) 300.3240e) 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. (Section 2-107 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 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	S9999		

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S9999	Continued From page 1	S9999		

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)

These Requirements are not met as evidenced by:
Based on interview and record review, the facility failed to ensure that a resident was not subjected to a mental and emotional abuse.

Findings include:
The facility Preliminary 24-Hour Incident Investigation Report dated 10/10/14 showed that approximately two weeks ago, R1 was being readied for the shower by E5 (CNA - Certified Nursing Assistant). Both R1 and E5 were in the resident's room. According to R1, E5 took off her clothes and place her in the shower chair. E5 covered her with a sheet and began to take R1 out into the hallway to the shower room. R1 told E5, "I won't go out there like this." The CNA responded, "Yes you will." R1 stated that when E5 pushed the chair into the doorway, R1 put her hands onto the door jambs to prevent her from going through the door. R1 repeated, "I'm not going out there." E5 repeated, "Yes you are." E5 then forced the chair through the doorway against the resident's will.

R1 was readmitted to the facility on 4/14/13 with diagnoses which include Congestive Heart Failure, Paralysis Agitans and Parkinson's Disease. R1's quarterly MDS (Minimum Data Set) dated 7/9/14 and 10/8/14 showed under Cognitive Patterns: BIMS (Brief Interview for Mental Status) score of 15 that indicates that R1 was alert and coherent and able to express herself.

E3 (Director of Nursing) stated during Daily

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S9999	Continued From page 2 Status Report on 10/15/14 at 4:00 PM that R1 was alert, coherent and oriented. E3 also verified that R1's BIMS score was 15. E3 (Director Of Nursing) also stated that on 10/9/2014, Z1(R1's family member) informed her that R1 felt mentally, emotionally abused and that her rights were violated when E5(Certified Nurse Assistant) had given shower to R1 on 9/22/2014. On 10/15/14 at 11:30 AM, R1 stated that few weeks ago, the CNA (E5) brought the shower chair to the room in preparation for R1's shower that afternoon. R1 said that E5 was upset about something and bad mouthing the administration. R1 stated that E5 placed her in the shower chair in spite of her protest that the shower seat was open and not covered. R1 also said that E5 did not listen to her questions and protest and continued to undress her, wrapped her body with a sheet. R1 stated that when E5 pushed the shower chair towards the door, she resisted by placing her hands on both door jambs to prevent from going through the door. R1 continued to protest but E5 did not listen and forced the shower chair through the door against R1's will. R1 said that she did not report the incident to anyone right away but called her POA (Power of Attorney). R1 told another CNA (E10) about what happened few days later. R1 also told E10 that she did not want E5 to take care of her. E10 told E4 (LPN - Licensed Practical Nurse) of R1's wishes. E10 then approached the resident and verified that R1 did not want E5 to take care of her. R1 did not tell E4 the reason why because E4 knew why. R1 further said that she felt mentally and emotionally abused when E5 forcibly pushed the chair into the hallway against her will. R1 felt that everybody can see her bare behind (buttocks). R1 also felt that her rights were violated.	S9999		

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S9999	Continued From page 3 On 10/15/2014 at 2:40 P.M.,E10(Certified Nurse Assistant) stated that sometime around the 3rd or 4th week of September 2014, R1 was "obviously very upset, mad, embarrassed, humiliated and noted with increased shakiness." E10 stated that at that time, R1 made a complaint to E11(Registered Nurse, Nurse Supervisor) regarding E5. As E10 added, R1 informed her that E5 had taken R1 to the shower room in a manner that R1 felt humiliated, embarrassed and was partially clothed while taken to the shower room. E10 also added that R1 informed her that E5 insisted to take R1 to the shower room by pushing R1's on a shower chair while R1 placed her hands against the door jams to prevent going out of the room. E10 also added that she did not report the potential abuse to E3(Director of Nursing), E1(Administrator) and E2(Assistant Administrator) as R1 already notified E11. On 10/15/2014 at 3:30 P.M., E11(Registered Nurse/Nurse Supervisor) stated that sometime the 3rd or 4th week of September 2014, R1 informed her that she was mistreated by E5. E11 also added that R1 was visibly upset how E5 treated her and did not abide by her wishes. E11 also added that she did not report this potential abuse to E1, E2 and E3. On 10/15/2014 at 3:00 P.M., E4 (Licensed Practical Nurse) stated that on 9/27/2014 and 9/28/2014, R1 refused E5 to be her caregiver. E4 also stated that R1 did not show behavior of refusing care from E5 not until that time on 9/27 and 9/28/2014. E4 further stated that she did not asked R1 the reason why she refused care from E5. On 10/15/2014, at 4:00 P.M., E1, E2 and E3 had	S9999		

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S9999	Continued From page 4	S9999		

all stated that they were not notified by any staff regarding R1's potential abuse.

On 10/16/2014 at 4:10 P.M. , Z2(Attending Physician) stated R1 informed her as of today (10/16/2014) that a CNA had taken her to a shower room using a shower chair and that R1 was only covered with a sheet. Z2 also added that R1 had informed her that R1 resisted by placing her hands against the door jams, however, the CNA still insisted of taking R1 out of the room against her will. Z2 further stated that "I believe (R1) and there was no reason not to believe her. (R1) is cognitively intact and reliable."

As a result, there was a delay of investigation and had subjected R1 and other residents at the facility to a possible potential mistreatment from E5. The attendance record showed that E5 had continued to work at the facility as a CNA until 10/8/2014.

The facility's "Abuse Prevention" policy with a revised date of 9/2011 and 11/2011 states that "Any person who knows or has reasonable cause to suspect that a resident has been or is being abused, neglected, or exploited shall immediately report such knowledge to the administrator."

The policy also defines abuse as, "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." The policy further defines mental abuse as "humiliation, harassment, threats of punishment or deprivation."

(A)

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imposed

WINCHESTER HOUSE
HEALTHCARE AND REHABILITATION

1125 North Milwaukee Avenue
Libertyville Illinois 60048
Phone 847 377 7200
Fax 847 377 7250

October 27, 2014

Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F223

Resident #1 has been interviewed by IDON and Social Worker and states she currently feels safe and secure at the facility.

All residents may be affected by the alleged practice of not having their needs acknowledged and assisting them in a safe abuse/neglect free manner.

On 10/9/12 when IDON was notified of incident by the residents guardian and an investigation was started. The NAR (E5) who was named in this practice was immediately suspended and has since been terminated. The facility had done a background check, checked references and checked registry prior to hiring the NAR. Upon hire she had received vulnerable adult education on the facilities abuse policy. The facility provides training upon hire, annually and on a prn basis. The RN (E11) has also been suspended pending investigation of the allegation that she was aware of the residents' allegation and did not act upon this by reporting to administration. Per facility internal interviews with E 11 she states this was not reported to her at a level she felt was abuse only that it was a concern related to the residents bathing preference and that resident # 1 reported to her she was cold after the shower, therefore she did not report to administration.

Staff is to receive education related to the VA policy, when and how to report VA issues. Residents will also receive education related to facility VA policy and to report allegations immediately to a trusted employee, the DON or the administrator.

Assistant Administrator / Designee will complete weekly audits x 3 months to assure staff is aware what VA issued are and the proper reporting of VA issues per facility policy.

Audits will be reviewed at QAA X3 months. Date certain will be 11/5/14.

acceptable