STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145900	A. BUILDING _____ B. WING _____	C 11/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW CR CTR-LEWISTOWN	**175 EAST SYCAMORE LEWISTOWN, IL 61542**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Incident report investigation to incident of 9/14/15/IL81124	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to recognize, report and thoroughly investigate an allegation of verbal abuse for one of two abuse allegations (R1) reviewed for abuse in a sample of six. Findings include: The Facility's incident report form dated 9/14/15 documents: "resident POA (Power of Attorney) around 2-3 p.m. noted a skinny CNA (Certified Nursing Assistant) across the hall from the room she was in being verbally inappropriate with a resident and had kicked the side of (R1 wheelchair) w/c pushing it back." The same form documents the date of incident was 9/13/15 and identified R1 as the resident. The signed witness statement of E3/CNA dated 9/14/15 documents E7 (CNA) "little out of line yesterday, told (R1) (R1) needed to quit putting himself on the toilet or he was going to hurt himself or one of us. This s--t is f---ing ridiculous. (E3/ CNA) finished (R1) up and told (E7/ CNA) (E7) could go do someone else." The facility's undated investigation summary documents: "date reported 9/14/15...a staff member whom was described in detail being verbally abusive towards another resident and pushed residents wheelchair backwards with (R1)	F 225		

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F 225	Continued From page 2	F 225		

sitting in it back into (R1's) room with (E7's) foot. Spoke with another CNA, (E3) who worked with (E7) (CNA) on the day this statement was reported. (E3/ CNA) reports that (E3) witnessed (E7) being verbally abusive to resident (R1) on this day as well."

E7's CNA time card dated 9/13/15 documented E7 completed E7's shift on 9/13/15, working until 10:00 p.m.

On 11/2/15 at 2:05 p.m. E3 CNA (Certified Nursing Assistant) stated that at the time of the incident on 9/13/15, "it didn't click that it was verbal abuse." E3 stated E3 took it as E7 CNA being moody and edgy." E3 stated that on 9/13/15 R1 was on the edge of R1's chair and E7 yelled at him. E3 stated telling E7 to take a break. E3 stated E3 completed R1's cares. E3 denied observing E7 kick R1's chair. E3 stated reporting the incident involving R1 to E1/Administrator and E2 DON (Director of Nursing) on Monday, 9/14/15.

On 11/3/15 at 8:15 a.m. E1, Administrator, stated the incident involving R1 which occurred on 9/13/15 was reported to the facility on 9/14/15 by visiting family, Z1. E1 stated Z1 stated a CNA (E7) was being rude to R1 by saying inappropriate things and stated E7 kicked R1's wheelchair. E1 stated E3/ CNA did not recognize the incident involving R1 on 9/13/15 as abuse and did not report it until interviewed by E2 DON on 9/14/15. On 11/3/15 at 12:30 p.m. E1 stated E1 did not interview any other residents or staff regarding the incident on 9/13/15.

On 11/3/15 at 8:40 a.m .E2/DON (Director of Nursing) stated the incident that occurred on

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F 225	Continued From page 3 9/13/15 was not reported to the facility until "after the fact." E2 stated E3/CNA (Certified Nursing Assistant) did not report the allegation of abuse, however confirmed it happened when interviewed by the facility on 9/14/15..	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy on abuse prevention by not immediately reporting an incident of verbal abuse to the facility administrator for one of two abuse allegations (R1) reviewed for abuse in a sample of six. Findings include: The facility's Abuse Prevention Program policy last revised on 7/23/15 documents under a section titled orientation and training of employees, "verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families..."' The same policy documents "employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately...employees accused of possible abuse, neglect or misappropriation of property	F 226		

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F 226	Continued From page 4	F 226		

shall not complete the shift as a direct care provider to residents." This same form documents "employees are required to report any incident, allegation or suspicion of potential abuse...they observe, hear about or suspect to the administrator or an immediate supervisor who must immediately report it to the administrator."

The Facility's incident report form dated 9/14/15 documents: "resident POA (Power of Attorney) around 2-3 p.m. noted a skinny CNA (Certified Nursing Assistant) across the hall from the room she was in being verbally inappropriate with a resident and had kicked the side of (R1 wheelchair) w/c pushing it back." The same form documents the date of incident was 9/13/15 and identified R1 as the resident.

The facility's undated investigation summary documents: "date reported 9/14/15...a staff member whom was described in detail being verbally abusive towards another resident and pushed residents wheelchair backwards with (R1) sitting in it back into (R1's) room with (E7's) foot. Spoke with another CNA, (E3) who worked with (E7) (CNA) on the day this statement was reported. (E3/ CNA) reports that (E3) witnessed (E7) being verbally abusive to resident (R1) on this day as well."

E7's CNA time card dated 9/13/15 documented E7 completed E7's shift on 9/13/15, working until 10:00 p.m.

On 11/2/15 at 2:05 p.m. E3/CNA (Certified Nursing Assistant) stated at the time of the incident on 9/13/15 "it didn't click that it was verbal abuse." E3 stated reporting the incident

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F 226	Continued From page 5 involving R1 to E1 Administrator and E2/DON (Director of Nursing) on Monday, 9/14/15. On 11/3/15 at 8:15 a.m. E1, Administrator stated the incident involving R1 which occurred on 9/13/15 was reported to the facility on 9/14/15 by visiting family, Z1. E1, Administrator, stated E3/CNA did not recognize the incident involving R1 on 9/13/15 as abuse and did not report it until interviewed by E2/ DON on 9/14/15. On 11/3/15 at 8:40 a.m., E2/ DON (Director of Nursing) stated the incident that occurred on 9/13/15 was not reported to the facility until "after the fact." E2 stated E3/CNA (Certified Nursing Assistant) did not report the allegation of abuse however confirmed it happened when interviewed by the facility on 9/14/15.	F 226		