STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146151	A. BUILDING _____ B. WING _____	C 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYBERG, THE	**625 EAST MONROE STREET CUBA, IL 61427**

(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	F 000		
F 223 SS=G	Complaint Investigation #1620841/IL83398 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one resident (R1) was free from verbal abuse for one of three allegations of abuse reviewed. This failure resulted in R1 being verbally abused by E1 (Administrator), and R1 being fearful of E1. Findings include: The facility policy, titled "Abuse Prevention, Identification and Reporting Program Policy and Procedure (dated 3/06/14)", documents "Verbal Abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...The facility makes every effort to provide a resident sensitive and secure environment." A Minimum Data Set, dated 1/12/16, documents R1 as having a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicative of R1 being cognitively intact, and without behavioral	F 223		

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

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issues or memory loss.

On 2/17/16 at 10:10 a.m., R1 stated E1 (Administrator) had recently "yelled" at her when she had questioned some charges from the beauty shop that were listed in her Resident Trust Account. R1 stated E1 "yelled" at her and "that wasn't right." R1 stated she was "scared" when E1 yelled at her, and is "still scared of (E1)." On 2/18/16 at 10:10 a.m., R1 was further questioned about the incident with E1. R1 still was unable to recall the exact date of the incident, but stated "(E1) yelled at me when I asked about the money and "it was hurtful...she spoke to me so rough. (E1) can be hard on us. I don't like (E1) to talk to me or anyone in that tone of voice. If she (E1) is going to speak to me that way, she shouldn't do that job." R1 stated she "certainly" felt the way E1 spoke to her was abusive.

On 2/17/16 at 10:20 a.m., E3 (Licensed Practical Nurse) stated several days prior, she and Z2 (visitor) and E4 (Registered Nurse) were at the Nurses Station and they observed R1 propel her wheelchair into the Administrators office. E3 stated she heard E1 yelling at R1, "You're just here to argue about money, aren't you (R1)? I told you very clearly that (E6 - Social Services) will be back tomorrow and that's who you need to talk to. But, no. You want to sit in here and argue with me, don't you?" E3 stated "R1 came out of E1's office crying and gasping and upset." E3 stated she immediately reported the incident to E2 (Director of Nursing). E3 stated "staff are afraid" of E1. E3 stated she believes E1 verbally abused R1.

On 2/17/16 at 1:15 p.m., E4 (Registered Nurse) stated, on what she believed to be 2/08/15, she

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F 223	Continued From page 2 overheard from the Nurses Station E1 "talking sternly" to R1. E4 stated E1 repeatedly said to R1, "Are you really wanting to argue with me about this (R1)?" E4 stated R1 left E1's office crying and E3 consoled R1. E4 stated, "If someone talked to me like that, I'd be visibly shaken. No one should be spoken to like that." On 2/17/16 at 12:40 p.m., Z2 (visitor) stated she was in the facility visiting her family member the week prior. Z2 stated she overheard E1 "talking loudly" to R1, "Are you going to sit here and argue with me today?" Z2 stated, "I was in awe, because it was so loud. It was an uncomfortable situation. It sounded bad." Z2 described E1's tone as "mean." Z1 stated R1 was crying about the incident afterwards at the Nurses Station. Z2 stated she observed E3 and E2 comforting R1 immediately after the incident occurred. On 2/23/15 at 9:50 a.m., the distance from the Nurses Station to the Administrator's office was measured. The doorway to Administrator's office is located 11 feet insided the Social Services office, just off the main hallway. The door to the Administrator's office is approximately 52 feet from the Nurses Station.	F 223		
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	F 225		

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F 225	Continued From page 3 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 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure E1 (Administrator) investigated an allegation of verbal abuse by E6 (Social Service Director) towards R1 and failed to ensure an additional allegation of verbal abuse by E1 towards R1 was immediately reported to the County Board and investigated, for two of three allegations of abuse reviewed.	F 225		

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F 225	Continued From page 4	F 225		

Findings include:

The facility policy, titled "Abuse Prevention, Identification and Reporting Program Policy and Procedure (dated 3/06/14)", documents "Verbal Abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...Employees of the facility who have been accused of abuse or mistreatment will be removed from duty immediately until the results of the investigation have been reviewed." The policy further documents, "The facility makes every effort to provide a resident sensitive and secure environment by: Timely response to allegation, problem or concern reporting and follow-up. Resident and families will be encouraged to report any allegations, problems or concerns immediately to ensure that their issues are addressed in a timely and comprehensive manner...Employees are required to immediately report any occurrences of potential and/or actual abuse or mistreatment they observe, hear about, or suspect to the Administrator...Upon receiving the report, the Administrator shall ensure the immediate initiation of an investigation."

On 2/17/16 at 11:45 a.m., E5 (Certified Nursing Assistant) stated the morning of 2/05/16 at approximately 10:00 a.m., she overheard E6 (Social Service Director) speak to R1, "in a loud, stern voice." E5 indicated she clearly heard E6 state to R1, "You need to knock it off." E5 stated E3 (Licensed Practical Nurse) was standing next to her at the time and E5 asked E3 if she heard the same. According to E5, E3 agreed that she heard the same and that E5 should report the incident to E1 (Administrator). E5 stated she

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F 225	Continued From page 5	F 225		

immediately went to E1 and told her what she had overheard E6 say to R1. E5 stated she "demonstrated the voice" she heard to E1, as she was suspecting it was verbal abuse. E5 stated E1 indicated she was going to go and "eavesdrop on the conversation." However, E5 stated she did not observe E1 ever go down the hall to investigate further. E5 stated neither she, nor E3 were questioned any further about what they overheard. E5 stated E6 has continued to be at work since the incident occurred.

On 2/17/16 at 10:20 a.m., E3 (Licensed Practical Nurse) stated she recalled overhearing E6 "yell" at R1; however, E3 could not recall the specific date the incident occurred, but knew that it had been recent. E3 stated R1's roommate had recently requested a room change, and she overheard E6 yell at R1 "It's absolutely ridiculous we can't keep anyone in the room with you." E3 stated she felt how E6 was speaking to R1 was abusive and it sounded as though E6 was scolding R1 for not being able to keep a roommate. E3 stated E1 never questioned her about the allegation.

On 2/17/16 at 2:05 p.m., E1 (Administrator) stated E5 (Certified Nursing Assistant) reported to her (on 2/05/16) that "(E6) is talking very loud to (R1) and I think you need to go look." E1 stated she went down the hall and overheard E6 talking with R1 about her roommate situation and E6's voice was not abnormal or loud at that time. E1 indicated E6 had been talking loud to R1 because her hearing aids were not in. E1 stated "abuse" never came up in the conversation and the incident was not investigated, nor did she speak with R1 in private about her conversation with E6, to determine if the resident felt

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threatened/abused. E1 stated E6 was not suspended, as E1 did not feel an allegation of abuse had been reported.

A Minimum Data Set, dated 1/12/16, documents R1 as having a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicative of R1 being cognitively intact, and without behavioral issues or memory loss.

On 2/17/16 at 10:10 a.m., R1 stated "I've been forgetting a lot lately" and could not recall the conversation between her and E6 in the days prior and denied ever feeling abused by E6; however, R1 stated E1 (Administrator) had recently "yelled" at her when she had questioned some charges from the beauty shop that were listed in her Resident Trust Account. R1 stated E1 "yelled" at her and "that wasn't right." R1 stated she was "scared" when E1 yelled at her, and is "still scared of (E1)." On 2/18/16 at 10:10 a.m., R1 was further questioned about the incident with E1. R1 still was unable to recall the exact date of the incident, but stated "(E1) yelled at me when I asked about the money and "it was hurtful...she spoke to me so rough. (E1) can be hard on us. I don't like (E1) to talk to me or anyone in that tone of voice. If she (E1) is going to speak to me that way, she shouldn't do that job." R1 stated she "certainly" felt the way E1 spoke to her was abusive.

On 2/17/15 at 10:20 a.m., E3 (Licensed Practical Nurse) stated several days prior, she and Z2 (visitor) and E4 (Registered Nurse) were at the Nurses Station and they observed R1 propel her wheelchair into the Administrators office. E3 stated she heard E1 yelling at R1, "You're just here to argue about money, aren't you (R1)? I

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told you very clearly that (E6) will be back tomorrow and that's who you need to talk to. But, no. You want to sit in here and argue with me, don't you?" E3 stated R1 came out of E1's office crying and "gasping and upset." E3 stated she immediately reported the incident to E2 (Director of Nursing). E3 stated "staff are afraid" of E1. E3 stated she believes E1 verbally abused R1.

On 2/17/16 at 1:15 p.m., E4 (Registered Nurse) stated, on what she believed to be 2/08/15, she overheard from the Nurses Station E1 "talking sternly" to R1. E4 stated E1 repeatedly said to R1, "Are you really wanting to argue with me about this (R1)?" E4 stated R1 left E1's office crying and E3 consoled R1. E4 stated, "If someone talked to me like that, I'd be visibly shaken. No one should be spoken to like that."

On 2/17/16 at 12:40 p.m., Z2 (visitor) stated she was in the facility visiting her family member the week prior. Z2 stated she overheard E1 "talking loudly" to R1, "Are you going to sit here and argue with me today?" Z2 stated, "I was in awe, because it was so loud. It was an uncomfortable situation. It sounded bad." Z2 described E1's tone as "mean." Z2 stated R1 was crying about the incident afterwards at the Nurses Station. Z2 stated she observed E3 and E2 comforting R1 immediately after the incident occurred.

On 2/17/16 at 11:00 a.m., E2 (Director of Nursing) stated E3 had reported to her last week that E1 was speaking loudly to R1. E2 stated she questioned R1 about what had occurred, but R1 indicated she didn't feel threatened. E2 denied seeing R1 crying about the incident. E2 stated she did question Z2 about what she overheard between E1 and R1, asking if it sounded

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F 225	Continued From page 8 threatening. E2 stated Z2 told her "it depends on the receiver." E2 stated she didn't do a formal investigation, because R1 told her she didn't feel threatened. E2 recalled E4 telling her the way E1 spoke to R1 "wasn't right." E2 stated she did not send the Administrator home after the allegation was reported to her, because she was "not sure I have the authority to do so." E2 stated the County Board is "over" E1. E2 didn't report the incident to anyone on the County Board. On 2/17/16 at 2:05 p.m., E1 (Administrator) stated she was unaware that an allegation of verbal abuse had been made against her. E1 stated the Chain of Command after her is the Health Committee of the County Board and that any concerns about her should have been reported to them. On 2/17/16 at 3:00 p.m., E7 (County Board Chairman) stated any allegation of abuse by E1 (Administrator) should have been reported to any one of the County Board Members to ensure a full investigation would be conducted. The Facility Accident/Incident Log for January and February 2016 did not idenifiy any allegations of abuse involving R1.	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.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow operational policies and procedures for the reporting and investigation of two separate allegations of verbal abuse towards R1 and failed to immediately suspend the alleged perpetrators (E1-Administrator and E6-Social Service Director), for two of three allegations of abuse reviewed.

Findings include:

The facility policy, titled "Abuse Prevention, Identification and Reporting Program Policy and Procedure (dated 3/06/14)", documents "Verbal Abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...Employees of the facility who have been accused of abuse or mistreatment will be removed from duty immediately until the results of the investigation have been reviewed." The policy further documents, "The facility makes every effort to provide a resident sensitive and secure environment by: Timely response to allegation, problem or concern reporting and follow-up. Resident and families will be encouraged to report any allegations, problems or concerns immediately to ensure that their issues are addressed in a timely and comprehensive manner...Employees are required to immediately report any occurrences of potential and/or actual abuse or mistreatment they observe, hear about, or suspect to the Administrator...Upon receiving the report, the Administrator shall ensure the immediate initiation of an investigation."

On 2/17/16 at 11:45 a.m., E5 (Certified Nursing

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Assistant) stated the morning of 2/05/16 at approximately 10:00 a.m., she overheard E6 (Social Service Director) speak to R1, "in a loud, stern voice." E5 indicated she clearly heard E6 state to R1, "You need to knock it off!" E5 stated she immediately went to E1 and told her what she had overheard E6 say to R1. E5 stated she "demonstrated the voice" she heard to E1, as she was suspecting it was verbal abuse.

On 2/17/16 at 2:05 p.m., E1 (Administrator) stated E5 (Certified Nursing Assistant) reported to her (on 2/05/16) that "(E6) is talking very loud to (R1) and I think you need to go look." E1 stated she went down the hall and overheard E6 talking with R1 about her roommate situation and E6's voice was not abnormal or loud at that time. E1 indicated E6 had been talking loud to R1 because her hearing aids were not in. E1 stated "abuse" never came up in the conversation and the incident was not investigated, nor did she speak with R1 in private about her conversation with E6, to determine if the resident felt threatened/abused. E1 stated E6 was not suspended, as E1 did not feel an allegation of abuse had been reported.

On 2/17/15 at 10:20 a.m., E3 (Licensed Practical Nurse) stated several days prior, she and Z2 (visitor) and E4 (Registered Nurse) were at the Nurses Station and they overheard E1 yelling at R1, "You're just here to argue about money, aren't you (R1)? I told you very clearly that (E6) will be back tomorrow and that's who you need to talk to. But, no! You want to sit in here and argue with me, don't you." E3 stated R1 came out of E1's office crying and "gasping and upset." E3 stated she immediately reported the incident to E2 (Director of Nursing), as she believed E1 verbally

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abused R1.

On 2/17/16 at 11:00 a.m., E2 (Director of Nursing) stated E3 had reported to her last week that E1 was speaking loudly to R1. E2 stated she questioned R1 about what had occurred, but R1 indicated she didn't feel threatened, so she didn't believe it was abuse. E2 stated she didn't do a formal investigation into the allegation. E2 explained that the Abuse Policy identifies E1 as the Abuse Coordinator, but does not direct staff on what to do if the Abuse Coordinator is the alleged abuser. E2 stated she did not send the Administrator home after the allegation was reported to her, because she was "not sure I have the authority to do so." E2 stated the County Board is "over" E1. E2 didn't report the incident to anyone on the County Board and was uncertain how to contact them.

On 2/17/16 at 2:05 p.m., E1 (Administrator) stated she was unaware that an allegation of verbal abuse had been made against her. E1 stated the Chain of Command after her is the Health Committee of the County Board and that any concerns about her should have been reported to them.

On 2/17/16 at 3:00 p.m., E7 (County Board Chairman) stated any allegation of abuse by E1 (Administrator) should have been reported to any one of the County Board Members to ensure a full investigation would be conducted.

The Facility Accident/Incident Log for January and February 2016 did not identify any allegations of abuse involving R1.