STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. BUILDING _____ B. WING _____	C 12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVANA HEALTH CARE CENTER	609 NORTH HARPHAM STREET HAVANA, IL 62644

(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 225 SS=D	Complaint Investigation #1526576/IL81874 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 incident, and if the alleged violation is verified	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	F 225		

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 an allegation of verbal abuse was immediately reported to the Administrator, for one of four residents (R1) reviewed for abuse, in a sample of four and failed to initiate an investigation and report an injury of unknown origin within 24 hours, for one of four residents (R3) reviewed for abuse in a sample of four.

Findings include:

1. An Incident Report Form, dated 11/30/15, documents "C.N.A. (Certified Nursing Assistant) reported that she observed another C.N.A. (E4) speak to (R1) in a rude manner. Accused Employee immediately removed from facility." The Incident Report Form identified the occurrence as alleged verbal abuse and occurring on 11/29/15 at 12:00 p.m.

An Incident Investigation Form, dated 11/30/15, documents the alleged verbal abuse was reported by E3 (Certified Nursing Assistant) to E1 (Administrator) on 11/30/15 at 10:06 a.m., the day after the incident occurred. The Incident Investigation Form documents E3 reported E4 (Certified Nursing Assistant) approached R1, who was incontinent of urine while sitting in a chair by the Nurses Station, and spoke to R1 with a "loud and rude tone." According to the Incident Investigation Form, E4 stated to R1, "Why are you sitting there, you are soaked with urine. Why would you do that?"

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F 225	Continued From page 2 On 12/02/15 at 8:40 a.m., E1 stated E3 did not report the allegation of "rude" comments made to R1 by E4 (on 11/29/15) immediately to her, as instructed in the facility policy. E1 confirmed E3 waited until the following day (11/30/15) to call the facility and report the incident. 2. The facility's Incident Report Investigation dated 10-2-15 states the following: "On 9-26-15 (R3) was observed with pain and guarding to left leg...to ER (emergency room)...returned at 9am with diagnosis of left subacute to healing fracture of lateral condylar of femur." The facility Incident Report fax form dated 9-26-15 documents this incident was not reported to the State Agency until 9-28-15 at 9:49 am. On 12-3-15 at 9:30 am, E1 (Administrator) stated they did not report R3's fracture until 9-28-15 as the DON (Director of Nursing) was the one on call and did not realize the injury of unknown origin needed to be reported on 9-26-15. E1 stated they did not initiate the investigation until 9-28-15, except for the interview of R3 on 9-26-15 by the nurse on duty. E1 stated, per the facility policy, R3's fracture should have been reported to the State Agency within 24 hours and that an investigation should have been initiated immediately and was not.	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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F 226	Continued From page 3	F 226		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure operational policies regarding resident abuse were followed, for two of four residents (R1 and R3) reviewed for abuse, in a sample of four.

Findings include:

The facility's "Abuse Prevention Program" (dated 11/11/11) defines verbal abuse as "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families..." The "Abuse Prevention Program" instructs employees to "immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents...they observe, hear about, or suspect to a supervisor and the administrator. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made ...and IDPH (State Agency) immediately after forming the suspicion. Otherwise, the report must be made not later that 24 hours after forming the suspicion." The "Abuse Prevention Program" further documents "Employees of this facility who have been accused of mistreatment, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct

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F 226	Continued From page 4	F 226		

care provider to residents." The policy also states "The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee...Upon learning of the report, the administrator or designee shall initiate an investigation."

1. An Incident Report Form, dated 11/30/15, documents "C.N.A. (Certified Nursing Assistant) reported that she observed another C.N.A. (E4) speak to (R1) in a rude manner. Accused Employee immediately removed from facility." The Incident Report Form identified the occurrence as "alleged" verbal abuse and occurring on 11/29/15 at 12:00 p.m.

A Incident Investigation Form, dated 11/30/15, documents the alleged verbal abuse was reported by E3 (Certified Nursing Assistant) to E1 (Administrator) on 11/30/15 at 10:06 a.m., the day after the incident occurred.

On 12/02/15 at 8:40 a.m., E1 stated E3 did not report the allegation of "rude" comments made to R1 by E4 (on 11/29/15) immediately to her, as instructed in the facility policy. E1 confirmed E3 waited until the following day (11/30/15) to call the facility and report the incident; therefore, E4 remained in the facility to care for residents for the entirety of her shift on 11/29/15.

2. The facility's Incident Report Investigation dated 10-2-15 states the following: "On 9-26-15

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F 226	Continued From page 5 (R3) was observed with pain and guarding to left leg...to ER (emergency room)...returned at 9am with diagnosis of left subacute to healing fracture of lateral condylar of femur." The facility Incident report fax form dated 9-26-15 documents this incident was not reported to the State Agency until 9-28-15 at 9:49 am. The facility's interviews/investigation reports are all dated as being initiated on 9-28-15. On 12-3-15 at 9:30 am, E1 (Administrator) stated they did not report R3's fracture until 9-28-15. E1 stated they did not initiate the investigation until 9-28-15, except for the interview of R3 on 9-26-15 by the nurse on duty. E1 stated per the facility policy, R3's fracture should have been reported to the State Agency within 24 hours and that an investigation should be been initiated immediately and was not.	F 226		