STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145801	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW LUTHER HOME	**505 COLLEGE AVENUE OTTAWA, IL 61350**

(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 7/19/16/IL87556.	F 000		
F 223 SS=G	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 interview, observation, and record review the facility failed to protect two residents (R1 and R3) from verbal and physical abuse by staff members (E3 and E18) for two of three abuse allegations reviewed. This resulted in R1 being subjected to physical and emotional abuse by E3 causing bruising and fear to the point of shaking. Findings include: 1. On 8/10/16 at 3:00 pm, Z1 (R1's family) stated the following: "I put the audio/video camera in (R1's) room after (R1) made comments that (E3/Certified Nursing Assistant/CNA) was not helping (R1) wipe, stand up, or dress; (R1) told Z1 that (E3) was not nice and made (R1) sit in the dining room for hours in the morning; E3 washed (R1's) genitals and stuck the washcloth in (R1's) face and then (E3) laughed at (R1); I (Z1) changed out the camera card everyday and	F 223		

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

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F 223	Continued From page 1	F 223		

looked at it after about a week of recording; on the video I (Z1) saw (E3) not helping (R1) and (R1) fall back into a chair hard; I also saw (E3) come rushing up to (R1) and flipped (R1) off; the video on 7/14/16 night shift going into 7/15/16 morning showed (E4 /CNA) was in (R1's) room and (E3/ CNA) told (R1) that (R1) hit (E3) and that was when I (Z1) called the police; on the video I saw (E4) roll eyes at (R1); and E3 was aggravated on the video and (R1) was heard saying 'Why do you hate me' on the video."

On 8/10/16 at 10:40 am, R1 stated (R1) had diarrhea and needed help in the bathroom and E3/CNA refused to help (R1) and told R1 to clean up (R1's) own mess. R1 stated (R1) is unable to get up unassisted but "did the best I could." R1 also stated this made (R1) "feel pretty bad." R1 stated (R1) raised (R1's) fist but didn't hit (E3) because she is a lady. R1 stated E3 treated (R1) "like a sack of potatoes frequently and has grabbed (R1's) arms causing bruising.

On 8/11/16 at 1:00pm, E1/Administrator stated the following: (E1) was unaware there was a problem with E3, E4, and R1 until the police came to the facility on 7/19/16. E1 also stated Z1 provided an edited video tape on 7/29/16 showing E3 and E4 as being physically, mentally and verbally abusive to R1.

On 8/10/16 at 10:40 am, (R1) had a furrowed brow and (R1) raised (R1's) voice at times when talking about (E3). R1 also raised (R1's) fist during the interview while talking about wanting to hit (E3).

The Nurses Notes for R1, dated 7/19/16 documents R1 with multiple bruises of unknown

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F 223	Continued From page 2	F 223		

origin to the following areas: right arm, right elbow, back of right hand, left arm, upper tricep area, back of left elbow, back of left hand, left upper arm bicep area and to right bicep area.

The local Police Department Incident Report #201601856, documents an audio/visual recording showing some of the evidence of E3 CNA (Certified Nursing Assistant) abusing R1. This report documents that on 6/16/16 at 8:56 pm, "(R1) fell back into the bed from a standing positioning, and (R1's) head went back and over the other side of the bed. (E3) stood next to the bed and did not help (R1) up." The report documents that on 6/26/16 at 4:45 am, "(E3) approached (R1) quickly, got in (R1's) face, and extended her index finger in front of (R1's) face." The report documents that on 6/26/16 at 9:01 pm, "(R1) fell into (R1's) wheelchair while (E3) stood next to (R1). (R1) struck (R1's) left arm on the arm of the wheelchair and is in apparent pain." The report documents that on 6/30/16 at 4:25 am, "The view of the camera is blocked by a sheet, but (E3's) right arm jabs in a punching motion toward (R1). (R1) is heard moaning immediately after the movement. (E3) stepped back, then made two more quick punching motions toward (R1) with her left arm." The report documents that on 7/9/16 at 4:51 am, "(E3) approached (R1) quickly, got in (R1's) face, and extended her middle finger in front of (R1's) face." This report also documents that on 7/9/16 at 4:52 am, "(E3) approached (R1) with a white towel in her hand, and attempted to roughly wipe (R1's) face. (R1) raised (R1's) hands to stop her and their was a struggle in front of (R1's) face where (R1) repeatedly said, "No."

The local Police Department Incident Report

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#201601856, documents "(R1) told us that (E3) would be cleaning (R1's) testicles and would be very rough with (R1). (R1) went on to explain that (E3) would sometimes clean (R1's) privates with a rag and then wipe (R1's) face with the same rag. (R1) said this happened a few times that (R1) could recall. (R1) said (R1) would sometimes yell from the pain and (E3) would put her finger to her lips and tell (R1), 'Shhhh.' (R1) said (E3) would also squeeze (R1's) testicles too. (R1) said (R1) would tell (E3) not to do these things, but she did not listen. (R1) said there were times where (E3) would make a mean face at (R1) as well. (R1) said when (R1) would call for help and saw (E3) come in the room (R1) would shake because (R1) was so afraid. (R1) said (R1) kept these things to (R1's) self because (R1) was afraid to tell anyone."

The local Police Department Incident Report #201601856, also documents E3 CNA was arrested on 7/28/16 for two warrants: "The first warrant was for Aggravated Battery and the second for Abuse of a Long-term Healthcare Facility Resident."

2. The facility's Preliminary Incident Investigation Report, dated 2/11/16, documents "On 2/5/16 at approximately 11:45 am, two CNA's (E18 and E19) were completing a transfer with (R3). E19/CNA reported an allegation of excessive use of force and profanity by E18 CNA."

The facility's Initial Report to the State Agency, dated 2/11/16, documents E19 CNA (Certified Nursing Assistant) reported that E18 CNA "used excessive force" while using a mechanical lift to transfer R3. This report documents "(E19) reported observing (E18) force (R3's) foot down

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F 223	Continued From page 4 with her foot, while pulling the strap to the lift with excessive force. During that time, (E18) used profanity saying, 'Come on, what the f***!'. E19 said when completing the transfer, E18 pulled (R3's) hand forcefully off of the lift." The facility's corrective Action Document for E18 CNA, dated 2/10/16, documents E18's employment was discharged for "specific policy violations" as listed: "Conduct and Behavior, Employee Guidebook-Employee Guiding Concepts & Practices, and for Abuse & Neglect." On 8/11/16 at 1:30 pm, E1/ Administrator stated that E18 CNA was put on administrative leave on 2/5/16 and her employment was terminated on 2/10/16.	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 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	F 225		

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F 225	Continued From page 5 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 interview, observation, and record review the facility failed to identify abuse, report to the Administrator immediately, and do a timely investigation for two allegations of abuse involving two residents (R1 and R2) of three allegations of abuse reviewed. Findings include: 1. On 8/10/16 at 10:40am, R1 stated (R1) did have problems with E3/CNA (Certified Nursing Assistant), that E3 made (R1) feel like a "sack of potatoes", and has made (R1) "feel pretty bad." (R1) stated (E3) has grabbed (R1) causing bruises to (R1's) arms and (E3) refuses to help (R1). On 8/11/16 at 1:30pm, E5/SSD (Social Service	F 225		

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Director) stated E5 was notified of the 7/14/16 incident with R1 and E3 on 7/18/16, four days after the incident occurred. E5 stated she investigated a "customer service issue" where R1 stated E3 did not clean R1 up after a bowel movement and E5 discussed the investigation with E2/DON (Director of Nursing).

On 8/11/16 at 1:30pm, E2/DON stated on 7/18/16, E5/SSD investigated R'1s bruising of unknown origin and reported the results to (E2). E2 also stated if there was a further issue we would have reported to (E1/Administrator) but we did not feel this was an abuse allegation but a customer service issue with delivery of care.

On 8/11/16 at 1:00pm, E1 stated (E1) was unaware there was a problem with E3, E4, and R1 until the police came to the facility on 7/19/16. E1 also stated Z1 (R1's family member) provided an edited video tape on 7/29/16 showing E3 and E4 physically/mentally/verbally abusing R1.

2. R2's Admission MDS (Minimum Data Set), dated 5/19/16 documents R2 has upper extremity impairment on both sides and requires assist with bathing, dressing, hygiene, transfers and ambulation.

On 8/10/16 at 3:02pm, R2 stated about a month ago (R2) asked E3/CNA (Certified Nursing Assistant) for help to get ready for bed and E3 threw R2's pajamas at R2, pointed at (R2) and stated "you do it." R2 also stated (R2) wanted to brush (R2's) teeth before bed and E3 told (R2) "No. There was no time" and pointed towards (R2's) bed and told (R2) to get in bed. R2 stated E3 "was the rudest person I've known my whole life. I was in shock. I couldn't believe it. I've never

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been treated that way." R2 also stated (R2) reported this incident to E4/CNA and requested that (E3) not return to (R2's) room.

On 8/11/16 at 1:00pm, E1/Administrator stated, (E1) is not always notified of customer services issues. E1 stated if a CNA is not helpful (E1) may not always be told about it because E5 SSD (Social Service Director) starts the investigation, consults with E2 DON (Director of Nursing), and then E2 DON will do E2's investigation. E1 stated E2 will notify E1 if E2 and E5 feel it is an abuse issue.

On 8/10/16 at 3:02 pm, R2 visibly distressed with furrowed brow, clenched teeth and shook (R2's) head when talking about E3.

On 7/12/16 E5/SSD documented an interview on an undated plain sheet of paper with R2 regarding (R2's) complaints of the lack of care provided by E3 CNA. In this interview, E5 documented, "SSD entered room and (R1) was talking to CNA about delivery of care issues." "(R2) stated the concern dated back a week or two." "(R2) added that it made (R2) mad because (R2) thought E3 should be helping (R2) more. (R2 stated that (R2) did not care for (E3)her and did not want (E3) taking care of (R2) in the future."

The Preliminary Incident Investigation Report, dated 8/5/16, was completed by E2/DON, 25 days after R2 spoke with E5/ SSD. This Report documents, "(R2) states (E3/ CNA) refused to assist (R2) during dressing and allegedly refused to allow (R2) time to brush (R2's) teeth."

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F 225	Continued From page 8 An interview of R2 recorded on a plain sheet of paper, dated 7/29/16, for R2 documents E2 DON and E5 SSD spoke with R2 and (R2) stated E3/ CNA did not help (R2) with getting ready for bed, and told (R2) that (R2) could do it independently and E3 had "No time" when R2 asked E3 to brush (R2's) teeth.	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 the facility's Abuse Policy and Procedure for immediate reporting of allegations of abuse to the Administrator and timely investigation for two allegations of abuse involving two residents (R1 and R2) of three allegations reviewed. Findings include: The facility's Abuse and Neglect of a Resident policy and procedure, revised 12/8/15, documents "If a resident is alleging abuse or neglect (physical, sexual, verbal, emotional, mental) the staff member receiving the complaint will immediately notify their direct supervisor and the Coordinator of Abuse Prevention. An Internal Investigation will be initiated utilizing the preliminary investigation report. The Administrator	F 226		

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is the abuse coordinator and will be informed immediately."

1. On 8/11/16 at 1:30pm, E5 SSD (Social Service Director) stated E5 was notified of the 7/14/16 incident with R1 and E3 on 7/18/16, four days after the incident occurred while E5 was investigating R1's bruises of unknown origin. E5 stated (E5) discussed the investigation with E2/DON (Director of Nursing).

On 8/11/16 at 1:30pm, E2/DON stated on 7/18/16, E5 SSD investigated R'1s bruising of unknown origin and reported the results to (E2). E2 also stated if there was a further issue, "we (E2 and E5) would have reported to (E1/ Administrator) but we did not feel this was an abuse allegation but a customer service issue with delivery of care.

2. On 7/12/16 E5/SSD documented an interview on an undated plain sheet of paper regarding (R2's) complaints of the lack of care provided by E3 CNA. In this interview, E5 documented, "SSD entered room and (R1) was talking to CNA about delivery of care issues." "(R2) stated the concern dated back a week or two." "(R2) added that it made (R2) mad because (R2) thought E3 should be helping (R2) more. (R2 stated that (R2) did not care for her (E3) and did not want (E3) taking care of (R2) in the future."

The Preliminary Incident Investigation Report for R2, dated 8/5/16, was completed by E2/DON, 25 days after R2 spoke with E5/ SSD. This Report documents, "(R2) states (E3/ CNA) refused to assist (R2) during dressing and allegedly refused to allow (R2) time to brush (R2's) teeth."

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F 226	Continued From page 10 On 8/11/16 at 1:00pm, E1 Administrator stated (E1) was unaware their was a problem with E3/CNA (Certified Nursing Assistant), E4/CNA, and R1 until the police came to the facility on 7/19/16. E1 also stated she may not always be told about an incident or about an upset resident because E5/SSD (Social Service Director) starts the investigation into a complaint or allegation and then consults with E2/ DON (Director of Nursing). E1 said E2/ DON will do E2's investigation and if E2 and E3 feel it is abuse, they will notify me. E1 also stated was not aware of R2's concerns until 7/26/16.	F 226		