STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E095	A. BUILDING _____ B. WING _____	C 11/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATAVIA REHABILITATION & HEALTH CARE CENTER	**520 FABYAN PARKWAY BATAVIA, IL 60510**

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F 000	INITIAL COMMENTS Complaint Investigation Survey Complaint # 1576017 / IL 81231	F 000		
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 observation, interview and record review the facility failed to follow the facility's abuse prevention policy by not initiating a complete investigation in a timely manner, failed to remove the employee from resident contact, failed to inform the physician and the power of attorney (POA) of the allegation and failed to report to the state survey agency within the time. This applies to one of three (R3) residents reviewed for abuse in the sample of three. The findings include: R3 was admitted on May 30, 2014 with multiple medical conditions including anxiety, supraventricular and paroxysmal tachycardia, depression, and hypertension according to the November 2015 physician order sheet (POS). The nurse's notes dated October 31, 2015 at 7:07 PM showed R3 went out of the facility and walked towards the vehicle of her nurse who was on	F 226		

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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lunch, wanting to ask the nurse for her 7:00 PM medications. Other staff members came out to encourage R3 to go back inside the facility. R3 pulled away from the nurse and fell on her buttocks and threw her head back to the ground. R3 stated at that time that the nurse pushed her. R3 sustained a lump to posterior head and a small abrasion to right elbow. R3 was sent to the hospital on October 31, 2015 for evaluation and returned on November 1, 2015. No new orders were given.

On November 2, 2015 at 1:50 PM, R3 was sitting on her bed, alert and oriented x 4. R3 stated on October 31, 2015 (Saturday), she asked E5 (Licensed Practical Nurse/LPN) at 5:00 PM if she can be given her 7:00 PM medications at 7:00 PM. Shortly after 7:00 PM, R3 said she could not find her nurse (E5). R3 asked the other nurse, E6 (Registered Nurse/RN) where was E5. E6 told R3 that E5 was on break. R3 stated she asked if E6 could give her the medications and E6 told her to wait for her nurse. R3 stated she saw her nurse outside, sitting in her car. R3 said she went out to get E5. R3 said E6 followed her outside, pushed E5's car door shut and was in between her and E5. R3 stated E6's back was towards her and when E6 moved backwards, it knocked her off balance and she fell. R3 showed the hematoma she sustained on the back of her head and swollen right elbow due to abrasion. R3 stated she was still very tired because it had been too much stress for her and that her muscles were sore. R3 stated, "I just want my my pills on time." R3 was asked why she had to receive her 7:00 PM medications exactly at 7:00 PM. R3 responded because it was after supper and she would like to watch a program on TV at 7:00 PM. R3 stated the medication "blanks my mind and I

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have no worries." R3 stated it also helped her deal with the second year death anniversary of her husband which was on November 1, 2015 and was also missing a resident who became her friend and had recently been discharged. R3 cried at this time but was able to gain control. R3 stated staff "thinks its a big joke when I look for my nurse and ask for my pills and they just hide." R3 stated she dreads daily to find out which nurse would be working the evening shift that she would be asking for her 7:00 PM medications.

Staff who were interviewed had slight variations with their report of what had occurred.
- On November 2, 2015 at 3:15 PM, E2 (Director of Nursing/DON) stated when E6 followed R3 outside, R3 was acting and threw herself on the ground. E2 stated E4 (Assistant Director of Nursing/ADON) was the staff on call and was also working on October 31, 2015 who notified E2 of the incident. E2 stated she has not interviewed E5 and E6. E2 stated she investigates the fall incidents and E1 (Administrator) was the abuse coordinator and investigates the abuse allegations.
- On November 2, 2011 at 2:40 PM, E3 (Social Service Director) stated on November 1, 2015 (Sunday), E6 (RN) informed her of R3's allegation she pushed R3. E3 stated she interviewed R3 on November 1, 2015. E3 stated when E6 tried to get R3 back in the building, E6 tried to encourage R3 to go forward and somehow R3 fell backward and hit her head on the ground. On November 3, 2015 at 1:30 PM, E3 stated she did not interview other residents on November 1, 2015 unless directed by E1 (Administrator/ Abuse Coordinator).
- On November 3, 2015 at 10:00 AM, E4 (ADON) stated she was working on October 31, 2015. E4

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stated by the time she went out to see what happened, R3 was already on the ground with E5 (LPN) and E6 (RN) in front of the resident. E4 stated when she asked R3 what happened, R3 said E6 pushed her. E4 stated she interviewed both E5 and E6 on 10/31/15. E4 stated E6 encouraged R3 to go back in the building by touching R3 by the shoulder. R3 jerked her shoulders and said, "Don't touch me" and started stumbling and threw herself on the ground, then threw her head back and hit the pavement. E4 stated E5 reported the same information. E4 stated she sent a group text on October 31 to E1(Administrator) and E2 (DON) about the incident. E4 stated she also called E1 to inform of both the incident and allegation. E4 said E1 instructed her to follow the fall protocol and for everyone present to give a witness statement. E4 stated E5, E6, E7 (Certified Nursing Assistant/CNA) and E8 (CNA) filled out a statement. E4 stated R3 and E6 were separated but E6 continued to work the shift. E4 said E1 was responsible for reporting abuse allegations to the state agency.

- On November 3, 2015 at 11:20 AM, E5 (LPN) stated on a telephone interview R3 sought her out while she was on break in her car. E5 stated E6 came out and tried to guide R3 back to the building without touching R3. E5 stated she needed to make a phone call and was on break and that it was only 7:07 PM.
- On November 3, 2015 at 11:40 AM, E6 (RN) stated she worked on October 31, 2015 on the evening shift (2:00 PM - 10 :00 PM). E6 stated that on October 31, she informed R3 after dinner at approximately 7:00 PM E5 was on her break. R3 requested her medications and E6 told R3 she could not give the medications because she did not have the key to the medication cart. E6

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warned R3 not to go out. Then E6 heard the front door alarm ring. E6 went to check and saw R3 outside walking towards E5's car. E6 stated it was drizzling that day and the parking lot was wet. E6 stated she motioned R3 to go back in the building and "lightly guided R3's right arm with her left hand." R3 jerked her right arm back and took several steps backward and landed on her buttocks. Several seconds later R3 threw her body backward and hit the back of her head on the pavement. E6 stated E4 (ADON) arrived and R3 told E4, "Did you see her push me?" E6 stated she had no further interaction with R3 after returning in the building. On November 3, 2015 at 1:55 PM, E6 stated she informed the physician and the POA of the fall incident but did not inform them of the allegation.

On November 3, 2015 at 1:00 PM, E1 (Administrator) stated she sent the initial report to the state survey agency on November 2, 2015. E1 stated she was the abuse coordinator. E1 stated E4 (LPN) informed her on October 31, 2015 of R3's fall. E1 stated she instructed E4, E5 and E6 via speakerphone to send R3 to the hospital, obtain statements from E5 (LPN) and E6 (RN) and to separate E6 from R3. E1 stated that abuse allegations should be reported immediately to the state survey agency. E1 stated since R3 alleged that E6 pushed her, it would be considered an abuse allegation. E6 stated the reason for not sending the report to IDPH (Illinois Department of Public Health/ state survey agency) until November 2 was because she was out of the area. There was no designee identified to manage the event.

The interview notes showed interviews of CNAs (E7 and E8) were conducted by E6 (alleged staff)

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F 226	Continued From page 5 on October 31, 2015. Resident interviews of R4 through R11 were not conducted until November 2, 2015. The facility policy titled, "Abuse Prevention Program," revised November 11, 2011, requires, "IV. Internal Reporting Requirements and Identification of Allegations...Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, neglect and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation. V. Protection of Residents...Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct provider to residents. VI. Internal Investigation of Allegations and Response 1. Appointing an Investigator. Once the administrator or designee receives an allegation of mistreatment, neglect or abuse...the administrator will appoint a person to take charge of the investigation. VII. External Reporting of Potential Abuse 1. Initial Reporting of Allegations. The report must be made not later than 24 hours after forming the suspicion. A written report shall be sent to the Department of Public Health... The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment, neglect, and abuse of residents and misappropriation of resident property and that an investigation is being conducted.	F 226		