| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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<br><br>Incident Report Investigation to Incident of 3-2-16/ IL#84061 - F223, F224, F225, F226, and F279 cited.<br><br>Incident Report Investigation to Incident of 3-9-16/ IL84059 - No deficiencies cited.<br><br>A Partial Extended Survey was conducted. | F 000 | | |
| F 223 SS=G | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION<br><br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to protect a resident (R2) from repeated verbal and physical abuse by a staff member, for one of three abuse allegations reviewed. This failure resulted in R2 suffering severe shoulder pain causing R2 to scream as a result of the physical abuse by a staff member.<br><br>Findings include:<br><br>E1's (Administrator) Abuse/Neglect Investigation Report dated 3-3-16 regarding (R2) documents, | F 223 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WESLEY VILLAGE** | **1200 EAST GRANT STREET MACOMB, IL 61455** |

| (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 223 | Continued From page 1 | F 223 | | |

"Investigation: 3/3/16 3:45 p.m. (E5/Licensed Practical Nurse) reported to (E6/Social Services Director) that an incident was reported to (E5) last night around 10:00 p.m. by (E3/Certified Nursing Assistant). (E3) witnessed treatment of a resident that (E3) did not feel was appropriate. (E6) reported incident to (E1/Administrator) immediately and initiated investigation...Initial report by witness: (E3) reported the following to (E5) at 10:00 p.m. on 3/2/16. (R2) was given a whirlpool bath around 8:30 p.m. on 3/2/16 by (E4 Certified Nursing Assistant). (E3) said (E3) entered the whirlpool room as (E3) heard (R2) yelling. (R2) was sitting on the bath chair and (E4) was working on getting (R2's) clothes off to begin bath. (E3) witnessed (E4) pulling (R2's) arm up and forcing (R2's) hand into (R2's) mouth. (E3) heard (E4) say, 'Go ahead bite yourself.' (E4) saw (E3) enter the room and stopped immediately and said, 'Don't even start I'm having a bad day.' (E3) left the room and returned to care for another patient. A few minutes later as (E3) was walking by the room (E3) witnessed (E4) spraying water directly in (R2's) eyes...Resident Interview: 3/3/16 4:00 p.m. (E6) interviewed (R2) about the incident during bathing on 3/2/16. (R2) said the following, '(E4) slaps and hurts me when (E4) takes my clothes off. Then it was blurry cause (E4) was spraying me with water in my face. I don't want (E4) to do anything for me anymore. (E4) acts this way every time and I'm scared.'...Perpetrator Interview: Called (E4) into (E1's) office at 4:05 p.m. 3/3/16 and asked if (E4) if there were any issues last night during bath given to (R2). (E4) said no. Asked if (E4) had sprayed (R2) in eyes. (E4) said no (E4) had washed (R2's) hair but not sprayed directly in face or eyes. Told (E4) that (R2) said (E4) was rough and slaps and hurts (R2) when undressing (R2). (E4) said no (E4)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 223 | Continued From page 2 | F 223 | | |

was not rough with (R2) and that (R2) doesn't like to take a bath so (R2) is resistant. (E4) said all CNA's (Certified Nursing Assistants) have trouble with (R2) at bath time. (E1) informed (E4) that (E4) was terminated immediately and to leave the facility at 4:10 p.m. 3/3/16."

On 3-16-16 at 10:00 a.m., R2 stated, "A few weeks ago a staff got rough with me. (E4) jerked my arms in the shower and hurt my shoulder. I told (E4) that (E4) hurt my shoulder, and then (E4) jerked my arm harder. (E4) then sprayed me in the the eyes with water and slapped me. (E4) was having a bad night and was taking it out on me. My shoulder hurts really bad."

On 3-16-16 at 10:00 a.m., E1 (Administrator) verified that on 3-2-16 around 8:00 p.m. to 8:30 p.m., (E3/Certified Nursing Assistant) witnessed E4 physically and verbally abusing R2. E1 verified that E3 reported the alleged abuse to E5 (Licensed Practical Nurse) that same night around 10:00 p.m, but (E5) did not report the incident until around 3:30 p.m. to 4:00 p.m. the next day (3-3-16.) E1 stated, " We (facility staff) have trained and trained on reporting of abuse. (E3) should have reported to the nurse when (E3) saw (E4) shove (R2's) hand to (R2's) mouth. (E3) should have pulled (E4) out of the shower room, initially, and reported to the nurse immediately. (E4) should have been suspended immediately. The incident should have been reported on 3-2-16."

On 3-16-16 at 2:20 p.m., E3 (Certified Nursing Assistant/CNA) stated, "On 3-2-16 (R2) was getting a whirlpool bath. I heard (R2) screaming, so I went into the shower room. I saw (E4/CNA) taking (R2's) shirt off. (R2) has a bad shoulder

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WESLEY VILLAGE** | **1200 EAST GRANT STREET MACOMB, IL 61455** |

| (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 223 | Continued From page 3 | F 223 | | |

and cannot lift (R2's) arm that high, so (R2) was yelling in pain. (E4) lifted (R2's) arm to (R2's) mouth and was telling (R2) 'Bite yourself. I am not dealing with this today.' I walked out of the shower room and went to help another resident. I then heard (R2) screaming again, so I went back into the shower room. (E4) was spraying (R2) in the eyes with the shower hose. At that time I helped (E4) transfer (R2) to the chair, and myself and (E4) took (R2) to bed. (R2's) shower was around 8:00 to 8:30 p.m. that night. I told the nurse (E5/Licensed Practical Nurse) around 9:20 p.m. to 9:30 p.m. of this incident with (E4) and (R2). The incident caught me off guard. I was in shock. I know I should have removed (E4) from the situation and reported immediately, but did not."

On 3-17-16 at 9:20 a.m., E7 (Medical Director/R2's Physician) stated, "I expect residents most definitely to be free of abuse. This incident (3-2-16 incident between R2 and E4) is definitely considered abuse. (R2) has degenerate joint disease of both shoulders, gout, and is diabetic. (R2's) range of motion is very limited. Telling (R2) to bite self and spraying (R2) in the face is horrible. I do not know of any other definition of abuse besides these acts. The CNA should not have lifted (R2's) arm up to (R2's) mouth with as much pain as (R2) has in the shoulders. The CNA should have been removed from the shower room when the other CNA witnessed (R2) in pain and (E4) telling (R2) to bite self." During this same time, E7 stated, "Well it (incident 3-2-16) must have had some effect of (R2) to recall the event from 3-2-16. She does not normally have a good memory."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 4 | F 224 | | |
| F 224 SS=L | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN | F 224 | | |

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 record review and interview, the facility neglected to immediately remove a resident (R2) in order to provide protection and immediately report the incident when physical abuse to R2 was witnessed as required by the facility abuse policy. These failures resulted in R2 being abused a second time by the same staff person (E4). The failures occurred for one of three allegations of abuse reviewed and have the potential to affect all 68 residents cared for by E4.

This failure resulted in an Immediate Jeopardy.

While the immediacy was removed on 3/18/16, the facility remains out of compliance at a Severity Level II. Additional time is needed to monitor the effectiveness of facility Abuse policy revision, staff re-education for the Abuse policy, care plan updating for residents with behaviors and weekly Certified Nursing Assistant shower auditing.

Findings include:

The facility's Abuse and Neglect Prevention

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WESLEY VILLAGE** | **1200 EAST GRANT STREET MACOMB, IL 61455** |

| (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 224 | Continued From page 5 | F 224 | | |

Policy, dated 12/4/14, documents, "It is the facility's policy to not tolerate verbal, sexual, physical, or mental abuse, involuntary seclusion or neglect of its residents by any individual...All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are to be reported immediately to the Administrator or his/her designated representative...The facility will protect residents from harm during the investigation of allegations with the following guidelines. The facility reserves the right to discipline, suspend or terminate any employee who the facility reasonably believes has abused, neglected, involuntarily secluded any resident or misappropriated any resident's property."

R2's Minimum Data Set (MDS) dated 1-29-16, documents R2 has diagnoses of Arthritis (Degenerative Joint Disease) and Pain.

An Electronic Communication dated 3-7-16 and signed by E1 (Administrator) documents, "(E4) was intentionally spraying water in a resident's (R2) eyes during a bath, and holding (R2's) forearm towards (R4's) mouth, telling (R2) to bite self. (E4) was terminated 3-3-16."

On 3-16-16 at 10:00 a.m., R2 stated, "A few weeks ago a staff got rough with me. (E4) jerked my arms in the shower and hurt my shoulder. I told (E4) that (E4) hurt my shoulder, and then (E4) jerked my arm harder. (E4) then sprayed me in the the eyes with water. (E4) slapped me. (E4) was having a bad night and was taking it out on me. My shoulder hurts really bad. No one

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 6 | F 224 | | |

else has abused me here, besides (E4)."

On 3-16-16 at 10:00 a.m., E1 (Administrator) stated, "On 3-2-16(E3/Certified Nursing Assistant) went into the shower room and saw (E4/CNA) having hold of (R2's) forearm, holding it up to (R2's) mouth, and telling (R2) to bite self. (E4) let go of (R2's) arm when (E4) was (E3). (E4) told (E3) 'Don't start with me. I am having a bad night.' (E3) left the shower room and later heard (R2) hollering again. (E3) saw (E4) spraying water directly into (R2's) eyes. (E3) then helped (E4) take (R2) to bed. (E3) did not report this to (E5/Licensed Practical Nurse) until around 10:00 p.m. This incident occurred around 8:00 p.m. to 8:30 p.m. (E5) did not report the incident until around 3:30 p.m. to 4:00 p.m. the next day (3-3-16.) We (facility staff) have trained and trained on reporting of abuse. (E3) should have reported to the nurse when (E3) saw (E4) shove (R2's) hand to (R2's) mouth. (E3) should have pulled (E4) out of the shower room, initially, and reported to the nurse immediately. (E4) should have been suspended immediately. (E4) was terminated for resident abuse, mostly physical, but verbal abuse also because (E4) told (R2) 'Go ahead and bite yourself'. The incident should have been reported on 3-2-16."

On 3-16-16 at 11:15 a.m., E1 verified that (E4) worked the remainder of (E4's) shift on 3-2-16, and worked from around 2:06 p.m. to 4:00 p.m. on 3-3-16.

On 3-16-16 at 2:20 p.m., E3 (Certified Nursing Assistant/CNA) stated, "On 3-2-16 (R2) was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 7 | F 224 | | |

getting a whirlpool bath. I heard (R2) screaming, so I went into the shower room. I saw (E4/CNA) taking (R2's) shirt off. (R2) has a bad shoulder and cannot lift (R2's) arm that high, so (R2) was yelling in pain. (E4) lifted (R2's) arm to (R2's) mouth and was telling (R2) 'Bite yourself. I am not dealing with this today.' I walked out of the shower room and went to help another resident. I then heard (R2) screaming again, so I went back into the shower room. (E4) was spraying (R2) in the eyes with the shower hose. At that time I helped (E4) transfer (R2) to the chair, and myself and (E4) took (R2) to bed. (R2's) shower was around 8:00 to 8:30 p.m. that night. I told the nurse (E5/Licensed Practical Nurse) around 9:20 p.m. to 9:30 p.m. of this incident with (E4) and (R2). The incident caught me off guard. I was in shock. I know I should have removed (E4) from the situation and reported immediately, but did not."

On 3-16-16 at 11:00 a.m., E5 (Licensed Practical Nurse) stated, "On 3-2-16 around 10:00 p.m., (E3) reported to me that (E3) witnessed (E4) spraying water into (R2's) eyes, and holding (R2's) arm up to (R2's) face telling (R2) to bite self. I should have reported this that night but did not report till the next day. (E4) worked the entire shift that night, and worked both hallways. I knew I should have reported immediately."

On 3-16-16 at 12:00 p.m., E6 (Social Service Director) stated, "(E5/Licensed Practical Nurse) reported to me on 3-3-16 around 3:30 p.m. that one of the certified nursing assistants told (E5) that (E4) was rough with (R2), spraying (R2) in the face, and holding (R2's) arms down the night

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 8 | F 224 | | |

before (3-2-16). I told (E1) immediately, and spoke with (R2). (R2) told me that (E4) hurt (R2's) shoulder and was rough during (R2's) bath. (R2) told me (E4) sprayed water in (R2's) face and slapped (R2)."

On 3-17-16 at 8:15 a.m., E6 (Social Service Director), who is also R2's Power Of Attorney, stated, "I was informed of an incident on 3-2-16 that occurred in the shower room. I was notified that (R2) was sprayed in the face with water and (E4) was holding (R2's) hands while giving (R2) a bath. (R2) was really unhappy. (R2) did not want (E4) to take care of (R2) anymore. (R2) told me (E4) sprayed (R2) in the face with water, hurt (R2's) shoulder when taking off (R2's) clothes, and slapped (R2). I fell like that is physical abuse. You do not slap a resident. You must control yourself when taking care of a resident, and should never lash back at a resident."

On 3-17-16 at 9:20 a.m., E7 (Medical Director/R2's Physician) stated, "I expect residents most definitely to be free of abuse. This incident (3-2-16 incident between R2 and E4) is definitely considered abuse. (R2) has degenerate joint disease of both shoulders, gout, and is diabetic. (R2's) range of motion is very limited. Telling (R2) to bite self and spraying (R2) in the face is horrible. I do not know of any other definition of abuse besides these acts. The CNA should not have lifted (R2's) arm up to (R2's) mouth with as much pain as (R2) has in the shoulders. The CNA should have been removed from the shower room when the other CNA witnessed (R2) in pain and (E4) telling (R2) to bite self." During this same time E7 was questioned to what effect this would have on the resident, E7

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 9 | F 224 | | |

stated, "Well it must have had some effect on (R2) for (R2) to recall the event from (3-2-16). She does not normally have a good memory."

On 3-17-16 at 9:00 a.m., E2 (Director of Nursing) verified that E4 works all hallways in the facility.

E4's Timecard Report dated 3-2-16 through 3-3-16, documents E4 worked on 3-2-16 from 4:12 p.m. to 9:07 p.m., and 3-3-16 from 2:06 p.m. to 4:12 p.m.

On 3/17/16 at 10:15 a.m., E1 verified that on 6/11/15 E6 educated staff at the Residents Rights/Abuse & HIPAA (Health Insurance Portability and Accountability Act) in-service on the definitions of abuse and immediately reporting abuse to the Administrator.

A facility In-service sheet, dated 6/11/15, documents that E5 was in attendance for the "Residents Rights/Abuse and HIPAA" training. The In-service sheet also documents that E3 and E4 were not in attendance for the training. This inservice documents, "Elder abuse is any knowing, intended, or careless act that causes harm or serious risk of harm to an older person-physically, mentally, emotionally, or financially...Physical abuse: includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment...Verbal abuse: defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or with their hearing distance regardless of their age, ability to comprehend, or disability...What to do if you suspect neglect/abuse: Immediately notify the abuse

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 10 | F 224 | | |

coordinator; Care, treat, and protect the resident...Protection: The facility will protect residents from harm during the investigation of the allegations."

E5's Residents Rights and Abuse quiz, given during the 6/11/15 in-service, documents that E5 is aware that E5 is to report alleged abuse, neglect, or mistreatment to E1 and E2 immediately.

E4's Orientation check list, dated 1/29/14, documents that E4 received education on abuse from E8 (Licensed Practical Nurse) including video training, and E4 received a copy of the facility's abuse policy.

E3's Orientation check list, dated 10/13/14, documents that E3 received education on abuse from E8 (Licensed Practical Nurse) including video training, and E3 received a copy of the facility's abuse policy.

An unnamed document, dated 12/19/14 and signed by E5, documents that E5 received a copy of the facility Abuse policy, understands the guidelines of the policy, and will follow the policy.

The Facility Data Sheet dated 3-16-16 and signed by E1 (Administrator) documents 68 residents currently reside in the facility.

The Immediate Jeopardy was identified at 2:00 p.m. on 3-17-16 to have begun on 3-2-16 when R2 was abused by E4.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 224 | Continued From page 11<br><br>E1 and E2 were notified of the Immediate Jeopardy on 3-17-16 at 2:15 p.m.<br><br>The surveyor confirmed through interview and record review that the facility took the following action to remove the Immediate Jeopardy:<br><br>1. E4 was terminated on 3/3/16.<br><br>2. The facility provided all staff training by E1 (Administrator) on the facility's abuse policy and procedures regarding reporting, immediate notification of E1, immediate removal of the perpetrator, and signs of burnout or stress in care givers. Training to be completed by Friday 3-18-16 at 4:00 p.m.<br><br>3. E10 (Restorative nurse) reviewed bathing care plans with the CNAs for residents that have behaviors during bathing. Review of Care Plans will be completed by Friday 3-18-16 at 4:00 p.m.<br><br>4. Weekly audits will be completed by E1 with CNAs to get feedback on resident behaviors while bathing, and care plans will be updated by E11 (Care plan Coordinator) based on the input from bathing staff. | F 224 | | |
| F 225 SS=L | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>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 | F 225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 225 | Continued From page 12 | F 225 | | |

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 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 staff reported an allegation of verbal and physical abuse for one resident (R2) immediately to the Administrator and failed to remove the alleged perpetrator from the facility immediately, for one of three allegations of abuse

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 225 | Continued From page 13 | F 225 | | |

reviewed. These failures resulted in R2 being abused a second time by the same staff person (E4/Certified Nursing Assistant) and has the potential to affect all 68 residents in the facility that E4 has access to.

This failure resulted in an Immediate Jeopardy.

While the immediacy was removed on 3/18/16, the facility remains out of compliance at a Severity Level II. While the immediacy was removed on 3/18/16, the facility remains out of compliance at a Severity Level II. Additional time is needed to monitor the effectiveness of facility Abuse policy
revision and staff re-education for the Abuse policy
including post-testing all direct care staff regarding reporting abuse, immediate notification of the administrator, and resident protection from abuse by removing the perpetrator.

Findings include:

E1's (Administrator) Abuse/Neglect Investigation Report dated 3-3-16 regarding (R2) documents, "Investigation: 3/3/16 3:45 p.m. (E5/Licensed Practical Nurse) reported to (E6/Social Services Director) that an incident was reported to (E5) last night around 10:00 p.m. by (E3/Certified Nursing Assistant). (E3) witnessed treatment of a resident that (E3) did not feel was appropriate. (E6) reported incident to (E1/Administrator) immediately and initiated investigation...Initial report by witness: (E3) reported the following to (E5) at 10:00 p.m. on 3/2/16. (R2) was given a whirlpool bath around 8:30 p.m. on 3/2/16 by (E4 Certified Nursing Assistant). (E3) said (E3) entered the whirlpool room as (E3) heard (R2)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 225 | Continued From page 14 | F 225 | | |

yelling. (R2) was sitting on the bath chair and (E4) was working on getting (R2's) clothes off to begin bath. (E3) witnessed (E4) pulling (R2's) arm up and forcing (R2's) hand to (R2's) mouth. (E3) heard (E4) say, 'Go ahead bite yourself.' (E4) saw (E3) enter the room and stopped immediately and said, 'Don't even start I'm having a bad day.' (E3) left the room and returned to care for another patient. A few minutes later as (E3) was walking by the room (E3) witnessed (E4) spraying water directly in (R2's) eyes...Resident Interview: 3/3/16 4:00 p.m. (E6) interviewed (R2) about the incident during bathing on 3/2/16. (R2) said the following, '(E4) slaps and hurts me when (E4) takes my clothes off. Then it was blurry cause (E4) was spraying me with water in my face. I don't want (E4) to do anything for me anymore. (E4) acts this way every time.'...Perpetrator Interview: Called (E4) into (E1's) office at 4:05 p.m. 3/3/16 and asked if (E4) if there were any issues last night during bath given to (R2). (E4) said no. Asked if (E4) had sprayed (R2) in eyes. (E4) said no (E4) had washed (R2's) hair but not sprayed directly in face or eyes. Told (E4) that (R2) said (E4) was rough and slaps and hurts (R2) when undressing (R2). (E4) said no (E4) was not rough with (R2) and that (R2) doesn't like to take a bath so (R2) is resistant. (E4) said all CNA's (Certified Nursing Assistants) have trouble with (R2) at bath time. (E1) informed (E4) that (E4) was terminated immediately and to leave the facility at 4:10 p.m. 3/3/16."

On 3-16-16 at 10:00 a.m., R2 stated, "A few weeks ago a staff got rough with me. (E4) jerked my arms in the shower and hurt my shoulder. I told (E4) that (E4) hurt my shoulder, and then (E4) jerked my arm harder. (E4) then sprayed me in the the eyes with water. (E4) slapped me.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 225 | Continued From page 15 | F 225 | | |

(E4) was having a bad night and was taking it out on me. My shoulder hurts really bad."

On 3-16-16 at 10:00 a.m., E1 (Administrator) verified that on 3-2-16 around 8:00 a.m. to 8:30 a.m., (E3/Certified Nursing Assistant) witnessed E4 physically and verbally abusing R2. E1 verified that E3 reported the alleged abuse to E5 (Licensed Practical Nurse) that same night around 10:00, but (E5) did not report the incident until around 3:30 p.m. to 4:00 p.m. the next day (3-3-16.) E1 stated, " We (facility staff) have trained and trained on reporting of abuse. (E3) should have reported to the nurse when (E3) saw (E4) shove (R2's) hand to (R2's) mouth. (E3) should have pulled (E4) out of the shower room, initially, and reported to the nurse immediately. (E4) should have been suspended immediately. The incident should have been reported on 3-2-16."

On 3-16-16 at 11:15 a.m., E1 verified that (E4) worked the remainder of (E4's) shift on 3-2-16, and worked from around 2:06 p.m. to 4:00 p.m. on 3-3-16.

On 3-16-16 at 2:20 p.m., E3 (Certified Nursing Assistant/CNA) stated, "On 3-2-16 (R2) was getting a whirlpool bath. I heard (R2) screaming, so I went into the shower room. I saw (E4/CNA) taking (R2's) shirt off. (R2) has a bad shoulder and cannot lift (R2's) arm that high, so (R2) was yelling in pain. (E4) lifted (R2's) arm to (R2's) mouth and was telling (R2) 'Bite yourself. I am not dealing with this today.' I walked out of the shower room and went to help another resident. I then heard (R2) screaming again, so I went back into the shower room. (E4) was spraying (R2) in the eyes with the shower hose. At that time I

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WESLEY VILLAGE** | **1200 EAST GRANT STREET MACOMB, IL 61455** |

| (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 225 | Continued From page 16 | F 225 | | |

helped (E4) transfer (R2) to the chair, and myself and (E4) took (R2) to bed. (R2's) shower was around 8:00 to 8:30 p.m. that night. I told the nurse (E5/Licensed Practical Nurse) around 9:20 p.m. to 9:30 p.m. of this incident with (E4) and (R2). The incident caught me off guard. I was in shock. I know I should have removed (E4) from the situation and reported immediately, but did not."

On 3-16-16 at 11:00 a.m., E5 (Licensed Practical Nurse) stated, "On 3-2-16 around 10:00 p.m., (E3) reported to me that (E3) witnessed (E4) spraying water into (R2's) eyes, and holding (R2's) arm up to (R2's) face telling (R2) to bite self. I should have reported this that night but did not report till the next day. (E4) worked the entire shift that night, and worked both hallways. I knew I should have reported immediately."

On 3-17-16 at 9:20 a.m., E7 (Medical Director/R2's Physician) stated, "I expect residents most definitely to be free of abuse. This incident (3-2-16 incident between R2 and E4) is definitely considered abuse. (R2) has degenerate joint disease of both shoulders, gout, and is diabetic. (R2's) range of motion is very limited. Telling (R2) to bite self and spraying (R2) in the face is horrible. I do not know of any other definition of abuse besides these acts. The CNA should not have lifted (R2's) arm up to (R2's) mouth with as much pain as (R2) has in the shoulders. The CNA should have been removed from the shower room when the other CNA witnessed (R2) in pain and (E4) telling (R2) to bite self."

On 3-17-16 at 9:00 a.m., E2 (Director of Nursing) verified that E4 works all hallways in the facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 225 | Continued From page 17 | F 225 | | |

E4's Timecard Report dated 3-2-16 through 3-3-16, documents E4 worked on 3-2-16 from 4:12 p.m. to 9:07 p.m., and 3-3-16 from 2:06 p.m. to 4:12 p.m.

On 3/17/16 at 10:15 a.m., E1 verified that on 6/11/15 E6 educated staff at the Residents Rights/Abuse & HIPAA (Health Insurance Portability and Accountability Act) in-service on the definitions of abuse and immediately reporting abuse to the Administrator.

A facility In-service sheet, dated 6/11/15, documents that E5 was in attendance for the "Residents Rights/Abuse and HIPAA" training. The In-service sheet also documents that E3 and E4 were not in attendance for the training. This inservice documents, "Elder abuse is any knowing, intended, or careless act that causes harm or serious risk of harm to an older person-physically, mentally, emotionally, or financially...Physical abuse: includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment...Verbal abuse: defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or with their hearing distance regardless of their age, ability to comprehend, or disability...What to do if you suspect neglect/abuse: Immediately notify the abuse coordinator; Care, treat, and protect the resident...Protection: The facility will protect residents from harm during the investigation of the allegations."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 225 | Continued From page 18 | F 225 | | |

E5's Residents Rights and Abuse quiz, given during the 6/11/15 in-service, documents that E5 is aware that E5 is to report alleged abuse, neglect, or mistreatment to E1 and E2 immediately.

E4's Orientation check list, dated 1/29/14, documents that E4 received education on abuse from E8 (Licensed Practical Nurse) including video training, and E4 received copy of the facility's abuse policy.

E3's Orientation check list, dated 10/13/14, documents that E3 received education on abuse from E8 (Licensed Practical Nurse) including video training, and E3 received copy of the facility's abuse policy.

An unnamed document, dated 12/19/14 and signed by E5, documents that E5 received a copy of the facility Abuse policy, understands the guidelines of the policy, and will follow the policy.

The Facility Data Sheet dated 3-16-16 and signed by E1 (Administrator) documents 68 residents currently reside in the facility.

The Immediate Jeopardy was identified at 2:00 p.m. on 3-17-16 to have begun on 3-2-16 when R2 was abused by E4.

E1 and E2 were notified of the Immediate Jeopardy on 3-17-16 at 2:15 p.m.

The surveyor confirmed through interview and record review that the facility took the following

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WESLEY VILLAGE** | **1200 EAST GRANT STREET MACOMB, IL 61455** |

| (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 225 | Continued From page 19<br>action to remove the Immediate Jeopardy:<br><br>1. E4 was terminated on 3/3/16.<br><br>2. The facility provided all staff training by E1 (Administrator) on the facility's abuse policy and procedures regarding reporting, immediate notification of E1, and immediate removal of the perpetrator. Training to be completed by Friday 3-18-16 at 4:00 p.m. | F 225 | | |
| F 226 SS=L | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to follow operational policies and procedures regarding immediately notifying the Abuse Coordinator, protecting the resident, and removing the suspected perpetrator for one resident (R2) in one of three abuse allegations of abuse reviewed. This had the potential to affect all 68 residents residing in the facility.<br><br>These failures resulted in an Immediate Jeopardy.<br><br>While the immediacy was removed on 3/18/16, the facility remains out of compliance at a Severity Level II as the facility revises operational policies and procedures on Abuse. | F 226 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 226 | Continued From page 20 | F 226 | | |

Findings include:

The facility's Abuse and Neglect Prevention Policy, dated 12/4/14, documents, "It is the facility's policy to not tolerate verbal, sexual, physical, or mental abuse, involuntary seclusion or neglect of its residents by any individual...All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are to be reported immediately to the Administrator or his/her designated representative...The facility will protect residents from hard during the investigation of allegations with the following guidelines. The facility reserves the right to discipline, suspend or terminate any employee who the facility reasonably believes has abused, neglected, involuntarily secluded any resident or misappropriated any resident's property."

E1's (Administrator) Abuse/Neglect Investigation Report dated 3-3-16 regarding (R2) documents, "Investigation: 3/3/16 3:45 p.m. (E5/Licensed Practical Nurse) reported to (E6/Social Services Director) that an incident was reported to (E5) last night (3-2-16) around 10:00 p.m. by (E3/Certified Nursing Assistant). (E3) witnessed treatment of a resident that (E3) did not feel was appropriate... (E1) informed (E4/Certified Nursing Assistant) that (E4) was terminated immediately and to leave the facility at 4:10 p.m. 3/3/16."

On 3-16-16 at 10:00 a.m., E1 (Administrator) stated, "(E3) did not report this (3/2/16 incident involving R2) to (E5/Licensed Practical Nurse) until around 10:00 p.m. This incident occurred around 8:00 p.m. to 8:30 p.m. (E5) did not report

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 226 | Continued From page 21 | F 226 | | |

the incident until around 3:30 p.m. to 4:00 p.m. the next day (3-3-16.)...(E3) should have reported to the nurse when (E3) saw (E4) shove (R2's) hand to (R2's) mouth. (E3) should have pulled (E4) out of the shower room, initially, and reported to the nurse immediately. (E4) should have been suspended immediately...The incident should have been reported on 3-2-16."

On 3-16-16 at 11:15 a.m., E1 verified that (E4) worked the remainder of (E4's) shift on 3-2-16, and worked from around 2:06 p.m. to 4:00 p.m. on 3-3-16.

On 3-16-16 at 2:20 p.m., E3 (Certified Nursing Assistant/CNA) stated, "On 3-2-16 (R2) was getting a whirlpool bath. I heard (R2) screaming, so I went into the shower room. I saw (E4/CNA) taking (R2's) shirt off. (R2) has a bad shoulder and cannot lift (R2's) arm that high, so (R2) was yelling in pain. (E4) lifted (R2's) arm to (R2's) mouth and was telling (R2) 'Bite yourself. I am not dealing with this today.' I walked out of the shower room and went to help another resident. I then heard (R2) screaming again, so I went back into the shower room. (E4) was spraying (R2) in the eyes with the shower hose. At that time I helped (E4) transfer (R2) to the chair, and myself and (E4) took (R2) to bed. (R2's) shower was around 8:00 to 8:30 p.m. that night. I told the nurse (E5/Licensed Practical Nurse) around 9:20 p.m. to 9:30 p.m. of this incident with (E4) and (R2). The incident caught me off guard. I was in shock. I know I should have removed (E4) from the situation and reported immediately, but did not."

On 3-16-16 at 11:00 a.m., E5 (Licensed Practical Nurse) stated, "On 3-2-16 around 10:00 p.m.,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 226 | Continued From page 22<br>(E3) reported to me that (E3) witnessed (E4) spraying water into (R2's) eyes, and holding (R2's) arm up to (R2's) face telling (R2) to bite self. I should have reported this that night but did not report till the next day. (E4) worked the entire shift that night, and worked both hallways. I knew I should have reported immediately."<br><br>On 3-17-16 at 9:00 a.m., E2 (Director of Nursing) verified that E4 works all hallways in the facility.<br><br>The Facility Data Sheet dated 3-16-16 and signed by E1 (Administrator) documents 68 residents currently reside in the facility.<br><br>The Immediate Jeopardy was identified at 2:00 p.m. on 3-17-16 to have begun on 3-2-16 when R2 was abused by E4.<br><br>E1 and E2 were notified of the Immediate Jeopardy on 3-17-16 at 2:15 p.m.<br><br>The surveyor confirmed through interview and record review that the facility took the following action to remove the Immediate Jeopardy:<br><br>1. The facility revised their Abuse and Neglect policy to include types of abuse on 3/17/16 at 3:30 PM. | F 226 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESLEY VILLAGE | 1200 EAST GRANT STREET MACOMB, IL 61455 |

| (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 279 | Continued From page 23 | F 279 | | |

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to implement a care plan addressing resistance to showers/bathing for one of three residents (R2) reviewed for care plans in the sample of three.

Findings include:

On 3-16-16 at 10:00 a.m., E1 (Administrator) stated, "(R2) is resistive to showers. (R2) fights (R2's) bath."

On 3-16-16 at 1:40 p.m., R2 stated, "I argue with the staff whenever they give me a bath. I only like showers, and some of the staff give me a bath. It hurts my hips way too bad to be lowered into the bath tub."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146047 | A. BUILDING _____ B. WING _____ | C 03/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WESLEY VILLAGE** | **1200 EAST GRANT STREET MACOMB, IL 61455** |

| (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 279 | Continued From page 24<br><br>On 3-16-16 at 1:30 p.m., E9 (Certified Nursing Assistant/CNA) verified that R2 does not like baths and can become resistive.<br><br>R2's Minimum Data Set Section G Functional Status dated 1-29-16, documents R2 requires physical help in part of bathing activity of one assist of staff.<br><br>R2's current Care Plan does not include a plan of care or interventions to care and treat R2's resistance to cares/bathing.<br><br>On 3-16-16 at 11:40 a.m., E1 stated, "(R2) does not have a care plan implemented about (R2's) needing assistance with showers/bathing or (R2) being difficult with showers. There should be a care plan about (R2) needing assistance with showers and (R2's) behaviors during showers." | F 279 | | |