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F 000	INITIAL COMMENTS Complaint Investigation #1612709 / IL85596	F 000		
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 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	F 225		

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

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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 and record review the facility failed to recognize a derogatory statement as a potential allegation of abuse. The facility failed to do an investigation of an allegation of abuse.

This applies to 2 of 3 residents (R1, R3) reviewed for abuse in the sample of 3.

1. On May 23, 2016 at 5:00 AM, E1 (Administrator) stated there were no abuse investigations since the annual survey of October 16, 2015.

On May 23, 2016 at 11:42 AM, Z1 (Certified Occupational Therapy Assistant) stated during a therapy session R1 reported a night shift CNA (Certified Nursing Assistant) called her a B****. She immediately took R1 to E5 (Social Service Director). E5 then took R1 and Z1 to the administrator office.

On May 23, 2016 at 2:32 PM, E1 (Administrator) stated on April 14 at 11:46 AM, E5 brought R1 and Z1 into his office. Z1 stated R1 had told her someone on the night shift called her a B****. R1 described the person as female, overweight, white in skin color and blonde. E1 stated he started an investigation and interviewed staff working, R1's roommate, other residents near R1's room. E1 stated the only CNA fitting the description was E4. E1 stated E4 did not work the wing that R1 resided on. E1 stated no one was

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suspended during the investigation. E1 stated the allegation was not reported because he felt it was not abuse. E1 defined verbal abuse as use of derogatory terms. E1 was asked if the B word was derogatory. E1 said it was. E1 stated in hind sight he should have reported the allegation. On May 24, 2016 at 4:00 PM, E1 was presented with R1's Point of Care documentation showing E4 worked with R1 on April 13, 14 and 15. E1 was asked if R1 was being protected from a potential abuser during the investigation. E1 stated "I guess not."

On May 24, 2016 at 8:58 AM, E7 Registered Nurse (RN) stated on the morning of April 16th she went into R1's room to check her oxygenation level. R1 grabbed her hand and said she needed to tell her something. R1 reported a girl who gets her up in the morning called her a "ornery B****. E7 stated R1 described a heavier woman in a blue top with white hair.

R1's Nurses Note dated April 14, 2016 at 11:54 PM, showed " ...There is a family member or friend at bedside. This nurse introduced self and visitor declined to introduce self. This nurse spoke with visitor about resident's accusation and informed visitor that this nurse was present last night and that no such behavior was witnessed..."

R1's Occupational Therapy Notes dated April 12, 2016, showed "...R1 states that the night staff is mean to her, will report to [the] DON [Director of Nursing]. On April 14, 2016, "...R1 stated that she did not sleep well last due to issues with staff. Assisted R1 to social services for complaint which was directed to the Administrator."

R1's Point of Care History was reviewed from

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April 7- April 17, 2016. E4 had recorded documentation on R1's record on April 7, 13,14 and 15 showing E4 had cared for R1.

2. On May 23, 2016 at 4:20 PM, E11 (CNA) stated she reported an allegation of abuse to E3 (RN). R3 reported to her that someone on the night shift slapped him the night before. R3 described a bigger woman wearing red. E11 stated she immediately went to E3 and reported the incident.

On May 23, 2016 at 7 :38 AM, E3 stated she reported an allegation of abuse to E2 (DON) three months ago. R3 reported that a night staff person slapped him on the face and felt it was intentional. R3 described a female with gray hair, heavy set and had a mole on her face. R3 did not know her name. E3 stated she reported the incident to management and completed a statement. E3 stated she was told by management that they would start an investigation and suspend individuals that met the description.

On May 23, 2016 at 3:20 PM, E2 stated E3 reported the allegation of abuse to her. E2 stated that the allegation was not investigated or reported. E2 stated no staff was suspended related to the incident.

The facility's Abuse Policy dated June 2014, showed " Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator. If the incident involves alleged abuse or neglect, the Administrator shall provide the Illinois Department of Public Health with initial notice of the allege abuse or neglect to

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F 225	Continued From page 4 the Department a copy of a report of the incident completed as soon as possible but no more than 24 hours after the incident becomes known. If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, then the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident... Verbal abuse means the use by an employee or agent of oral, written or gestured language that includes disparaging and derogatory terms to a resident or within his or her hearing, regardless of the resident's ability to comprehend or disability.	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 its abuse policy for protection of residents, investigating allegations and reporting an allegation of abuse. This applies to 2 of 3 residents (R1, R3) reviewed for abuse in the sample of 3. 1. R1's Occupational Therapy Notes dated April 12, 2016, showed "...R1 states that the night staff is mean to her, will report to DON. On April 14, 2016, "...R1 stated that she did not sleep well last	F 226		

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night due to issues with staff. Assisted R1 to social services for complaint which was directed to the Administrator."

R1's Physician Progress Note dated April 12, 2016,showed," Patient states that she becomes very fearful at night. R1 could not give any specifics. The daughter also said that she was accusing staff at the hospital of being mean at night."

R1's Nurses Note dated April 14, 2016 at 11:54 PM, showed " ...There is a family member or friend at bedside. This nurse introduced self and visitor declined to introduce self. This nurse spoke with visitor about resident's accusation and informed visitor that this nurse was present last night and that no such behavior was witnessed..."

On May 23, 2016 at 11:42 AM, Z1(Certified Occupational Therapy Assistant) stated during a therapy session R1 reported a night shift CNA called her a B****. She immediately took R1 to E5 (Social Service Director). E5 then took R1 and Z1 to the administrator office.

On May 23, 2016 at 3:20 PM, E2 (Director of Nursing) stated she first became aware of an allegation that staff were being mean to R1 was when E6 (RN-Registered Nurse) told her on April 14, 2016 at 10:00 PM. E2 stated E7 (RN) also reported an allegation of verbal abuse on the evening of April 16th.

On May 24, 2016 at 8:55 AM, E7 (RN) stated on the morning of April 16th she went into R1's room to check her oxygenation level. R1 grabbed her hand and said she needed to tell her something. R1 reported a girl who gets her up in the morning

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F 226	Continued From page 6 called her a "ornery B****. E7 stated R1 described a heavier woman in a blue top with white hair. On May 24, 2016, Z5 (Nurse Practitioner) stated R1 and her daughter brought up concerns of staff mistreatment. Z5 stated they were not able to give her any specifics about the mistreatment. Z5 stated she encouraged R1's daughter to speak with the DON. On May 23, 2016 at 2:32 PM, E1 (Administrator) stated, on April 14th at 11:46 AM, E5 brought R1 and Z1 into his office. Z1 stated R1 had told her someone on the night shift called her a B****. R1 described the person as female, overweight, white in skin color and blonde. E1 stated he started an investigation and interviewed staff working, R1's roommate, other residents near R1's room. E1 stated the only CNA fitting the description was E4. E1 stated E4 did not work the wing that R1 resided on. E1 stated no one was suspended during the investigation. E1 stated the allegation was not reported because he felt it was not abuse. E1 defined verbal abuse as use of derogatory terms. E1 was asked if the B word was derogatory. E1 said it was. E1 stated in hind sight he should have reported the allegation. On May 24, 2016 at 4:00 PM, E1 was presented with R1's Point of Care documentation showing E4 worked with R1 on April 13, 14 and 15th. E1 was asked if R1 was protected from an potential abuser during the investigation. E1 stated "I guess not." R1's Point of Care History was reviewed from April 7- April 17, 2016. E4 had recorded documentation on R1's record on April 7th, 13th,14th and 15th, showing she had cared for R1.	F 226		

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2. On May 23, 2016 at 4:20 PM, E11 (CNA) stated she reported an allegation of abuse to E3(RN). R3 reported to her that someone on the night shift slapped him the night before. R3 described a bigger woman wearing red. E11 stated she immediately went to E3 and reported the incident.

On May 23, 2016 at 7 :38 AM, E3 (RN) stated she reported an allegation of abuse to E2 (DON) three months ago. R3 reported that a night staff person slapped him on the face and felt it was intentional. R3 described a female with gray hair, heavy set and had a mole on her face. R3 did not know her name. E3 stated she reported the incident to management and completed a statement. E3 stated she was told by management that they would start an investigation and suspend individuals that met the description.

On May 24, 2016 at 12:00 PM, Z4 stated R3 told her in the middle of the night he got up to go to the bathroom and he must not have been moving fast enough and a nurse with a gloved hand slapped him multiple times. Z4 stated R3 described a woman dressed in red and white with black/gray/brown hair with a wart on the side of the nose. R3 said he could identify the person if he saw her. Z4 stated she and R3's daughter met with E2 multiple times the following days and were reassured that R3 was safe and the nurse would not be on R3's wing and an investigation was being done and the incident was reported.

On May 23, 2016 at 3:20 PM, E2 stated E3 reported the allegation of abuse to her. E2 stated that the allegation was not investigated or

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reported. E2 stated no staff was suspended related to the incident.

The facility's Abuse Policy dated June 2014, showed "B. Initial steps and reports of alleged abuse or neglect- 1. Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator. 2. If the incident involves alleged abuse or neglect, the Administrator shall provide the Illinois Department of Public Health with initial notice of the allege abuse or neglect to the Department a copy of a report of the incident completed as soon as possible but no more than 24 hours after the incident becomes known. 5. If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, then the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incidents . C. Investigation- 1. Interviews with all involved parties or potential witness will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer should take notes. 2. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. statements shall be taken from the suspect, the person making the allegation, the resident abused or neglected, other staff or resident who may have witnessed the incident, and any other person who may have information. D. Abuse or neglect examination and protection- 4. If an employee is the suspected perpetrator of the abuse, then the employee shall be kept separate from all residents until further orders.... Verbal abuse means the use by an employee or agent of oral, written or gestured language that

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F 226	Continued From page 9 includes disparaging and derogatory terms to a resident or within his or her hearing, regardless of the resident's ability to comprehend or disability.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide nursing care to a resident with dementia with behaviors. This applies to 1 of 1 resident (R2) reviewed for dementia care in the sample of 3. The findings include: R2's Physician Order Report dated May 1-31, 2016 shows R2 has diagnoses including unspecified dementia without behaviors, Alzheimer's disease with late onset, fracture of unspecified phalanx of right ring finger, mixed incontinence and anxiety disorder. R2's MDS dated February 4, 2016 shows a BIMS of 5 (severe cognitive impairment), requires extensive assistance of one person with personal hygiene and is incontinent of bowel and bladder. R2's care plan dated September 15, 2015 shows	F 309		

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R2 has the potential for mood disturbance and potential for drug related complications associated with psychotic medications related to her diagnoses of anxiety and dementia. R2 is to be monitored for mood and behaviors.

R2's Behavior log dated December 1- January 31, 2016 was reviewed for behaviors. On January 3, 2016 at 6:07 AM, R2 was physically abusive towards others, verbally abusive towards others and rejected care. R2 had no other behaviors documented.

R2's radiology report dated January 3,2016 showed,"Acute intra-articular fracture base of the phalanx 4th finger."

On May 23, 2016 at 8:05 AM, R2 was asked if she felt safe in the facility. R2 shrugged her shoulders and stated, "they hurt me. Last January, two or three girls came in and wanted to change my diaper I told them it wasn't wet they proceeded to change it. I was holding onto the bar with both hands and they tried to take my hand off I didn't want to and they broke my ring finger.

On May 23, 2016 at 8:15 AM, Z3 stated R2's finger was x-rayed and it was broken. Z3 provided the statement he typed and gave to the administrator. The statement showed, "on January 3, 2016 when seeing R1 this morning about 7:00 AM, I discovered that she had a broken finger, right hand and was in a lot of pain... R2 admits that her memory isn't as good as it use to be. Very early in the morning, either some time near 2:30 or 3:30, three people (Two white and one black) came in and woke me up, when they came in they scared me so I asked

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them what they wanted. They said they wanted to change my diaper and I told them that it wasn't wet, but they insisted that it was, and I resisted. I was holding on to both sides of the bed railing and they tried to take my fingers off and that is when they must have broke my finger. One of them said is it her ring finger. They said , No it is her other hand."

On May 23, 2016 at 4:40 PM, E9, Certified Nursing Assistant (CNA) stated on January 3, 2016 between 1-2:30 AM, she and E8 (CNA) went into R2's room to provide care. R2 had diarrhea and needed to be changed. R2 claimed she wasn't dirty. R2 became combative. E8 was holding R2's hands and I was cleaning her up. R2 grabbed the grab bar, I put my hand under her left hand to slowly release R2 hand. Not sure if I removed her right hand or if E8 did. When we got done I told E10 (Licensed Practical Nurse) that R2 was combative with cares. E9 stated she had received training on how to care for a combative resident. E9 stated they are to walk away making sure the resident is safe and reapproach when the resident is calm. E9 stated because there was a large amount of loose stool, R2 needed to be changed. E9 stated, "didn't occur to step back and reapproach. "

On May 24, 2016 at 4:50 PM, E8 stated on January 3, 2016 she and E9 went into R2's room to change her. She had loose stools and needed to be changed. R2 became combative and was striking out at us. E9 was holding R2's hands so I could clean her up. R2 started swearing at E9. I was holding R2 hands and E9 was cleaning her. R2 punched me in the stomach. We continued to clean her up and when we needed to reposition her, R2 would not let go of the side rail. She was

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holding on tight. E9 removed R2's hand from the side rail. R2 started swinging and we finished cleaning and changing her. When we were done her hands were fine. E8 stated they didn't stop when R2 became combative because they did not want R2's skin to break down.

On May 24, 2016 at 2:01 PM, E10 (Licensed Practical Nurse) stated that she was the night nurse on the dementia unit on January 3, 2016. E10 stated she was called to R2's room to assess R2's finger around 6:00 AM. R2 was complaining of pain. The finger was bruised. R2 stated that a "black girl bent my finger back." E10 called the dementia unit director and the administrator and reported the incident. E10 stated E8 and E9 "should have backed off and gone back when she settles down."

On May 23, 2016 at 2:30 PM, E2 (Director of Nursing) stated at the time of the incident R2 resided in the memory care unit. R2 had issues with being changed. E2 stated R2 was lying in bed and the CNAs should have stepped away and came back to continue care.

On May 24, 2016 at 2:32 PM, E1 (Administrator) stated the incident was investigated and determined there was no intention to cause harm by the CNAs. He stated it was a "training issue". E1 stated staff receive the required 12 hours of dementia training which include different approaches to utilize with the residents.

The facility's Garden Court 12 Hour Dementia Training dated October 2015, was reviewed. The training includes how to work with and manage challenging behaviors of residents. E8 and E9 education and training records were reviewed. E8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146102	A. BUILDING _____ B. WING _____	C 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	**2170 WEST NAVAJO DRIVE FREEPORT, IL 61032**

(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 309	Continued From page 13 completed the 12 hours of dementia training on April 22, 2015. E9 completed the dementia training on March 17, 2015. E8 and E9 did not receive additional training on dementia residents with combative behaviors following the incident of January 3, 2016.	F 309		