STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145631	A. BUILDING _____ B. WING _____	10/13/2005

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NEWMAN REHABILITATION & HCC	**418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942**

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F 225	Continued From page 18 Completion date: October 7, 2005. 8. The Administrator interviewed of all interviewable residents to ascertain any additional concerns the residents had and appropriate reports were written. The reports were reviewed by the Vice President of Clinical Operation and/or the Director of Clinical Operation. Completion date: October 12, 2005. 9. The Administrator or Director of Nursing is to notify the Vice President of Operations and/or the Director of Clinical Operations whenever there is a report of alleged abuse. A written report will be submitted for review prior to being sent to Public Health within the first 24 hours and a final report will be reviewed for approval and sent to Public Health within five days. Completion date: October 12, 2005.	F 225		
F9999	FINAL OBSERVATIONS Licensure Violations Section 300.3240 Abuse and Neglect 300.3240a) 300.3240b) 300.3240c) 300.3240e) a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility	F9999		

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F9999	Continued From page 19 administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These REQUIREMENTS ARE NOT MET as EVIDENCED by: Based on observation, interview, and record review the facility failed to protect 5 of 6 residents sampled for abuse/neglect, from verbal, mental and physical abuse (R17, R16, R6, R11, and R12). Because facility staff failed to report the force feeding of R17 by a Certified Nurses Assistant (CNA), an investigation was not conducted and the same CNA was allowed to use threatening language directed at R16. Because facility staff failed to report either of these two instances, the same CNA slapped R6 across the face. Again, because of the lack of reporting and lack of investigation of the previous three incidents, the same CNA continued to work and abused R11 by pulling her hair and abused R12 by forcing her down in bed by pushing on her forehead and chest.	F9999		

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F9999	Continued From page 20 Findings include: R17's most recent Physician's Order sheet dated October of 2005 shows R17 was a resident with diagnoses of left hemiplegia and debility. The clinical record showed that R17 expired on 5/04/05. R17 was on a pureed diet and her Minimum Data Assessment(MDS) dated 12/09/04 indicated R17 was cognitively impaired and her mental function varied over the course of the day. The assessment also showed R17 needed the extensive assist of one to eat. R16's most recent Physician's Order sheet dated October of 2005 shows R16 is a resident with diagnoses of Cerebral Vascular Accident and Depression. R16's most recent MDS dated July 2005 documents R16 with modified independent cognitive ability. The Director of Nurses on 10/12/05 identified R16 as someone who is not interviewable; attempts to interview R16 on 10/11/05 were not successful. Observation of R16 on 10/11/05 at approximately 12:30 PM demonstrated a resident on a pureed diet being fed by staff. Review of a facility document titled, "Notification of Suspected or Witnessed Abuse" and dated 6/21/05 indicated a CNA E4, witnessed the abuse of R16 and R17. The report stated, "(E3) was often verbally abusive to some of the residents. Telling them that they could not go to bed if they did not eat or physically forcing food in their mouth (R17). She told (R16) that she was sick of feeding her." The report was signed by E4. Interview with E4, CNA on 10/5/05 at approximately 2:30 PM showed that she had	F9999		

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F9999	Continued From page 21	F9999		

witnessed an abuse of R16 and one of R17 that she (E4) did not report. The CNA stated, "(R17) had no appetite (E3) CNA was feeding her. She did this by putting food in the liquid and forcing the cup in her (R17's) mouth. (R17) would turn her head and push the food away, keeping her mouth closed. She (E3) was force feeding her (R 17). She (E3) caused (R17) to cough and choke. A couple of times (E3) said things that made me cringe. She was feeding (R16) one day and (E3) said to (R16) in a gruff manner, 'I'm so sick of feeding you.' I considered this (both incidents) abusive behavior. I never reported (either of the incidents) to anyone. The former Assistant Director of Nurses (ADON) had admonished her (E3) for her tone of voice and the way she talked to the residents." E4 acknowledged the force feeding of R17 occurred sometime around Christmas of 2004 and the abuse of R16 some time after Christmas of 2004.

Interview with E6 CNA on 10/11/05 at approximately 2:20 PM stated E3 would talk to residents in a threatening manner. E6 stated, I would hear (E3) in the dining room threaten residents and I considered it abuse...I did not report it because I was sure the nurse heard it and would have reported it to the DON, (Director of Nurses). (E3 would say things like) "You have to eat this or you'll be the last one to bed. You can't go to bed if you don't eat."

Interview with E7 CNA on 10/11/05 at approximately 1:15 PM also confirmed a pattern of unreported abuse. E7 stated, "... I did not like the way (E3) talked to the residents at suppertime. She (E3) did not want to take time with the residents. She would say things like 'if

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F9999	Continued From page 22	F9999		

you don't eat you will be the last one put to bed.' She said that to (R17). I don't feel (E3) should have said that. I think what she said was abusive ."

According to R6's most recent Physician's Order Sheet dated October of 2005, R6 is a resident with a diagnosis of Alzheimers Disease. Review of R6's Resident Assessment Instrument dated 7/8/05 indicated R6 is cognitively impaired and needs extensive assist of 1 for dressing and extensive assist of one for transfer.

Review of a facility document titled, "Notification of Suspected or Witnessed Abuse" not dated, indicated a Certified Nurses Assistant (E8) witnessed abuse of R6 by E3 and did not report it right away. The report stated, "(E3) and (E8) was getting (R6) ready for bed and (E3) went to remove (R6's) dentures and resident was resisting care and (E3) got angry and slapped (R 6) in the face. (R6) then made remark that she 'had never seen such abuse in my life'...Have also seen (E3) pull resident's hair and push resident down in bed by placing hands on chest ..."

Interview with E8 CNA on 10/7/05 at approximately 10:55 AM confirmed the above report. E8 stated, "I worked second shift, 2-10 PM and I worked with (E3). She was loud with the residents - she didn't approach them in a calm manner. Some residents would become combative. On Saturday 6/18/05 (R6) was getting upset because (E3) went into her mouth to try to get her teeth out. (R6) became combative and (E 3) slapped her face. After the slapping incident, the same night (a good ten or fifteen minutes

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F9999	Continued From page 23	F9999		

passed) (E3) walked into (R11's) room and reached out and grabbed her hair and yanked it, there was no reason for it. (R11) was cognitively impaired but knew her hair had been pulled because she registered a look of pain and surprise. I didn't report the slapping or hair pulling incident right away because I did not think anything would be done." E8 estimated the time of the incidents to be between 6:30 and 7:30 PM and confirmed that E3 worked the rest of that evening until approximately 10:00 PM. E8 also verified that E3 worked alone with residents that night after the slapping/hair pulling incidents.

Review of a facility document identified as, "Time Log Report" for nursing for the dates 6/12/05 to 6/20/05 showed R3 worked until 10:06 PM on 6/18/05 (the date of the slapping/hair pulling incident) and also worked an entire shift from 1:56 PM until 10:05 PM on Sunday 6/19/05.

On 10/12/05 the Director of Nurses(DON) identified R6 as not interviewable. On 10/12/05 at approximately 11:45 AM R6 acknowledged that she (R6) was slapped in the face by a staff CNA. R6 stated when asked if she remembered being slapped in the face by a nurses assistant a few months ago, "Yes, I remember it." R6 denied knowing the CNA's name and denied being able to describe her. When asked if it hurt her R6 stated, "No, but I had to cry afterwards."

Interview with E8 CNA on 10/7/05 at approximately 10:55 AM demonstrated a concern by the CNA staff about E3 being abusive to residents. E8 stated, "We had suspicions about (E3) and we (E8 CNA, E6 CNA, E10 CNA, and E 12 CNA) were discussing it on our break. There

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F9999	Continued From page 24	F9999		

were suspicious bruises (chest and forehead) came up on (R12). I made the comment that it was (E3). (E12) talked to the 2-10 (2:00 PM to 10 :00 PM) nurse (E9 Licensed Practical Nurse, LPN) and (E9) came and talked to me. I told (E9) about my suspicions.... (E3) had pushed (R12) (by R12's chest)down in bed roughly, I witnessed it. It upset (R12)...I considered it an abusive act."

Interview with E9, LPN on 10/11/05 at approximately 1:40 PM confirmed she had been told about E8's concerns. E9 stated, "(E12) came and got me one night (probably a week or two before the slapping/hair pulling incident). (E12) said (E8) was out back talking about (E3)... and that I needed to talk with (E8). I asked (E8) if something was wrong and she told me she thought (E3) was being rough with the residents ...I called (E1 Administrator) right away. I told her what (E8) had said and asked (E1) what she wanted me to do. She (E1) said to have an in-service on handling (residents) and how we talk to people and I did." E9 also confirmed she knew about the bruising on R12, she stated, "Yes, I knew about the bruising on (R12), I didn't write up anything in the nurses notes or write up a skin sheet. By the time I saw them they were a couple of days old. I know one was on the chest. I don't know if anyone looked into them." Interviews with E1 Administrator, and E2 DON on 10/12/05 at approximately 2:00 PM indicated the facility was not able to find any documentation or any investigation about the bruising (injury of unknown origin) discovered on R12.

Interview with E1 Administrator on 10/11/05 at approximately 2:15 PM confirmed she was notified. E1 stated, "Yes, (E9) did call me at

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F9999	Continued From page 25 home and said a CNA (E8) had reported to her that (E3) was being rough with the residents. I thought it was gossip and I did not do an investigation. I had (E9) do an in-service. I did not talk to (E8) or any other CNA about the accusation." Review of a facility document identified as the abuse policy in effect at the time of these incidents showed the following: "Resident abuse must be reported immediately to the Director of Nursing and Administrator. The facility will complete a timely, thorough and objective investigation of all alleged violations...While a facility investigation is underway, steps will be taken to prevent further abuse...The nursing staff is responsible for the reporting the appearance of bruises, lacerations, or other abnormalities as they occur...If the source of the injury is unknown, A UKO INJURY INVESTIGATION report must be completed. An abuse investigation may also be conducted based on the investigation findings..."	F9999		