STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145600	A. BUILDING _____ B. WING _____	C 04/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HLTH CR CTR-CANTON	**2081 NORTH MAIN STREET CANTON, IL 61520**

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F 225	Continued From page 16 10. Survey allegations related to F223 and F225 were taken to QAA 4/13/06. 11. Per QAA recommendations 4/13/06; random staff interviews using QAA audit tool entitled ABUSE AND NEGLECT PREVENTION initiated 4/13/06 will be completed weekly on a random basis for the next 2 months. Completed audit tools will be reviewed by the QAA committee monthly. 12. Per QAA recommendations, all interviewable residents were re-interviewed on 4/13/06. 13. Per QAA recommendations on 4/13/06 non-interviewable residents were assessed again for any change in ADLs (Activities of Daily Living), appetite or behaviors. Declines identified were directly related to overall decline in health.	F 225		
F9999	FINAL OBSERVATIONS Licensure Findings 300.3240a) 300.3240b) 300.3240c) 300.1210a) 300.1210b)2 300.3220f) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall	F9999		

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F9999	Continued From page 17 immediately report the matter to the facility 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) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Based on interviews, observations, and record	F9999		

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F9999	Continued From page 18 review the facility failed to prevent the ongoing mental abuse by one facility staff member (E8) toward one resident (R1). The facility failed to follow their Abuse Prohibition Policy by not reporting multiple incidents of abuse witnessed by multiple staff members over a 5 month period, thus subjecting R1 to continued abuse. R1 had increased agitation with socially inappropriate behaviors when under the care of E8, LPN (Licensed Practical Nurse). Findings include: R1 is a 78 year old female resident with diagnoses of: Psychotic Disorder, Asthma, Chronic Obstructive Pulmonary Disorder, and Depression per current Physician's order sheet. MDS (Minimum Data Set) dated 1/20/06 documents that R1 is "Moderately" impaired for daily decision-making and "Highly Impaired" under vision. MDS documents that R1 exhibits verbal and physical abuse, socially inappropriate behaviors, and is resistive to cares 1 to 3 days in a 7 day period. Interview with R1 on 4/12/06 at 9:25 AM noted her as pleasant and smiling throughout the conversation. R1 stated, "One nurse on second shift was hateful to me. She doesn't work here any more. The "higher-ups" I think figured what she was all about. She was a smart nurse but she didn't like me. She was always telling me not to talk so loud. She took me to my room by jerking my wheel chair, I can't walk so I am stuck in this thing. She scared me, this went on for a couple of months. Boy she had it in for me, I don't know why. I don't think that I am that hard to get along with. You know when someone is	F9999		

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F9999	Continued From page 19	F9999		

hateful to you, after a while you get hateful back."

Final report faxed to IL Department of Public Health on 4/3/06 from the facility after allegations of abuse were made involving R1 and perpetrator (E8) LPN, (Licensed Practical Nurse) documents the following:

"On the 27th of March, 2006 it was brought to the attention of this facility that one of our employees had been abusing one of our residents from November of 2005 through January of 2006. The following instances of abuse have been substantiated through a thorough investigation by this facility and our corporate counterparts.

An employee eye witnessed the perpetrator throw water in the face of this resident. Another employee said that she overheard the perpetrator say 'I'll teach you'. This witness then saw the resident's hair had water on it.

An employee overheard the perpetrator deny the resident her breathing treatments. One nurse says she heard the perpetrator tell the resident that she did not need the treatment and told her 'you are not dead because you are still breathing' . Another nurse has overheard the perpetrator deny the breathing treatments stating that 'you are not wheezing, you are still breathing' with no lung assessments being done.

According to the involved resident a nurse had pushed her into her room and slammed the door. 'I almost fell out of my chair and that nurse threw water on me'. An employee eye witnessed the perpetrator push the resident in her wheelchair so hard that the chair spun around. Another employee saw the perpetrator grab the resident's wheelchair, turn it around quickly, take her to her

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F9999	Continued From page 20	F9999		

room and shut the door, leaving the resident in her room by herself. Another staff member states that she has seen the perpetrator go over and jerk the wheelchair and take her to her room real fast.

Based on three accounts given by other employees the perpetrator offered to pay them five dollars each if they would go mess with the resident's hair. It is common knowledge amongst the staff that messing with her hair causes great agitation on the part of this resident.

The perpetrator was suspended on the day we received the complaint and has not returned to work since. It is our belief that the abuse did occur and the perpetrator will be terminated on 4/04/2006."

Interview with E1, Administrator and E2, DON (Director of Nursing) on 4/10/06 at 9:20 AM corroborated the above report. E2 stated that she initiated the investigation on 3/26/06 after she came in to the facility that morning and read a statement left by E4, CNA (Certified Nurse Aide). The statement by E4 reads as follows:

"To the DON's (Director of Nursing) and ADON's (Assistant Director of Nurses) the reason I am writing this is to inform you of things that (E8) has been doing. I should have spoke up when I was asked about what I supposenly(sp) done to (R1). But on many occasions I saw (E8) throw water in (R1's) face. I also know that she treats (R1) like dirt tries her best to irratate(sp) her. Another time (R1) and her got into it and (E8) got upset with (R1) and pushed her hard enough into the room her chair spun around. Then on 3-24-06 she asked (E9) and I to touch (R1's) hair and she would pay us $5.00 and it was refused. Lalls

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	145600	A. BUILDING _____ B. WING _____	C 04/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HLTH CR CTR-CANTON	2081 NORTH MAIN STREET CANTON, IL 61520

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F9999	Continued From page 21 there are some 2nd shift nurses to verify." E4, CNA on 4/7/06 at 2:05 PM by phone stated the following: "At first, (E8) started tormenting (R 1), (E8) would be argumentative. Last November began seeing this more and more. (E8) began attacking (R1's) personal life. (E8) threw water on (R1) at end of December. (R1) got really upset and ballistic. In (R1's) care plan we're to push her to her room if she's loud or danger to other residents. One night (before the water incident) (R1) was at the nurses station being loud and obnoxious which is typical for her. (E8) got up from the nurses station, grabbed her chair and said, 'I have had it' in a mean tone. She pushed her in her wheel chair fast and (R1) spun around. (E8) stated, 'You just won a trip to your room." Other people saw her (E8) that night and other nights. When she left (R1) that night she slammed her door." E5, LPN (Licensed Practical Nurse) on 4/10/06 at 3:00 PM stated the following: "(R1) takes a breathing treatment. On numerous occasions (R 1) has come to the desk and asked (E8) for her breathing treatment. (E8) would say, 'You're breathing, you're not dead yet, you're not wheezing.' On one occasion (E8) said, 'I wish she would have a stroke so I could turn her every two hours tonight just to piss her off.' One night I heard (R1) yelling at (E8) and then (E8) said, 'That will teach you.' I looked up and (R1) was wet. I got a towel for (R1) and I said to (E8), 'That was not necessary.' (R1) was really upset. I didn't see anyone else in the area that could have thrown the water. A lot of nurses have seen and heard a lot of things. I was going to resign because I couldn't work with her any more. (E8)	F9999		

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F9999	Continued From page 22	F9999		

has also told me, 'I hate that b--ch' referring to (R 1). (R1) stated that (E8) was mean to her on several occasions and had been to the office several times. I had been gone for about 3 weeks due to illness. (E2), DON (Director of Nursing) called me and asked me about abuse regarding (E8) and (R1). I told (E2) that I would resign before working another shift with (E8). I have only been here a couple of months. I started seeing things toward the end of February 2006."

E6, LPN on 4/10/06 at 2:25 PM stated the following: "(R1) has complained about a second shift tall dark haired nurse throwing water on her. (R1) was very consistent with her story to me and (E7). (R1) also told me about this same nurse throwing her down on the bed. It happened 3-4 months ago. I told the former DON and former Administrator. I told the former Administrator that he needed to speak with R1. I assumed that it was being taken care of. I feel really bad that my report of abuse went no where. I started watching her notes. Another nurse documented on days that (R1) reported someone pushing her down. My opinion was that (R1) always acted better when (E8) was not here. I personally feel that these incidents did happen. I also noticed that (E8's) charting regarding (R1) was personal and judgmental. I don't have any problems caring for (R1); if I do, I approach her a few minutes later. I don't feel (E8) should be working anywhere in nursing. (R1) is telling the same story now about the water that she did 3-4 months ago."

E7, LPN on 4/10/06 at 11:15 AM stated the following: "(R1) can tell you all kinds of stories. I

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F9999	Continued From page 23 believed this was true regarding these incidents. The story never changed and remained consistent regarding (E8) throwing water on her, pushing her into her room, slamming the door and almost making (R1) fall out of her chair. (R1) first reported this to me at the beginning of the year. At one time during the week I took (R1) to the DON's office and told (E2), 'I think you need to hear this.' (E2), DON never came and talked to me and I am not sure that (R1) told her what she told me. In my opinion she (E8) should be pushing a pen but not taking care of residents." E10, LPN on 4/12/06 at 10:55 AM stated the following: "(E8) got aggravated one night and went around the nurses station and grabbed (R1 's) wheel chair and took her to her room. 15 - 30 minutes later (R1) came out and said that (E8) hit her in the head. I looked at her head and didn't see anything. I felt uncomfortable the way (E8) handled that situation. I would have never treated (R1) that way. I would say that (E8) was emotionally abusive to her. I never saw (E8) be physically abusive to (R1) but I had suspicions at that time and felt uncomfortable. This was in December of 2005 or January 2006. I did not report this to anyone. I didn't know whether people would believe me or not." E11, CNA on 4/12/06 at 12:50 PM stated the following: "There was an incident roughly one month ago. I was doing paper work at the nurses station, (E8) was sitting next to me. (E8) got up and grabbed (R1's) wheel chair and swung her around and pushed her quickly to her room, then she shut her door. (E8) didn't say anything to her ."	F9999		

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F9999	Continued From page 24	F9999		

E9, CNA on 4/10/06 at 1:45 PM stated the following: "(E8) made a joke in my presence as well as (E4) stating, "I'll give you $5.00 if you mess with (R1's) hair. We didn't of course."

E12, CNA on 4/10/06 at 4:00 PM stated the following: "Heard (E8) say, 'I'll give you $5.00 to mess with (R1's) hair.' No one touched her."

E13, facility beautician on 4/12/06 at 11:25 AM stated the following: "I only know what (R1) tells me. She told me that a second shift nurse threw water on her and jerked her around in her wheel chair. I heard her tell other people about the water and thought it was common knowledge."

Statements made by staff eye-witnesses during the facility's investigation all support the interviews obtained during survey.

Facility Abuse and Neglect Prevention System states under ACTIONS TABLE:

EMERGENCY HELP - Take immediate action to prevent further incidents and provide safety, including separating the resident from the area if necessary. Stay calm, remain with resident.

INVESTIGATE - Immediately, licensed nurse assigned to the resident and supervisor begins investigation of facts surrounding the alleged abuse. Interview nursing assistant, witnesses and bystanders if any. Caregivers, roommates, family and other bystanders are asked to contribute all knowledge of the resident and circumstances in completion of the investigation.

DETERMINE ABUSE - Notify the director of

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F9999	Continued From page 25	F9999		

nursing and the administrator of the unusual event and the investigation. The administrator holds ultimate responsibility for determining if abuse or neglect has occurred as well as immediate corrective actions such as suspension of employees. The administrator follows the center Quality Improvement, Occurrence Investigation.

NOTIFICATION - Notify physician, family and legal representative of the unusual event and assessment and interventions. Notify local and state authorities such as county or state health and policy according to state reporting requirements. Notify other staff members of unusual event using 24-Hour Report and Daily Stand Up meeting. Provide specifics to oncoming licensed nurse in shift report.

E1, Administrator and E2, DON (Director of Nursing) on 4/10/2006 at 9:20 AM stated that they have not been made aware of any abuse incidents involving R1 or any other residents. E2 stated that she first learned of R1's allegations of abuse when she came into work on 3/27/06 and found a letter written by E4 stating incidents of R 1 being abused. E1 stated that she has only been working within the facility for three weeks and had no knowledge of any abuse incidents for R1, or any other resident.

Interviews were done with E4 on 4/7/06 at 2:05 PM, and with E5, E6, E9, E12, and E14 (all licensed nursing staff or direct care staff) on 4/10/ 06 between 9:20 AM and 4 PM. All employees stated that they were aware of incidents of mental abuse by E8, LPN (Licensed Practical Nurse) directed at R1, but did not report it to

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F9999	Continued From page 26 facility administrative staff. E2, DON on 4/10/06 at 3:50 PM stated the following: "I remember (E7) bringing (R1) to my office and telling me that 'I need to hear this' from (R1). (E7) left and (R1) didn't say anything to me about being abused by (E8). Why she (E7) never told me specifically what (R1) told her I will never know." (A)	F9999		