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F 497	Continued From page 79 Employee file of E3 shows that she started working on 1-17-03. The file fails to show that the facility staff checked E3's previous references. Medical records staff (E25), reviewed the file on 8-20-06 and was also unable to locate verification of previous employment. A review of the inservices for abuse show that E3 did not attend the only previous inservices on abuse dated 4-4-05. On 8-20-06 at 1:37 PM, E25 reviewed the records and confirmed that E3's name was not on the inservice of 4-4-05.	F 497		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.610a) 300.695b)1)3) 300.695c)1)3)4)5) 300.695d) 300.3240a)b)c)d)e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

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F9999	Continued From page 80 Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor. 3) Sexual abuse of a resident by a staff member, another resident, or a visitor. c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification. 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure. 4) Seeking advice concerning preservation of a potential crime scene. 5) Facility investigation of the situation. d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c). Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

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F9999	Continued From page 81 resident. (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 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (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 REGULATIONS are not met as evidenced by: Based on facility data and interviews, the facility administration failed to make operational their policies and procedures pertaining to abuse. This systematic failure resulted in 6 allegations of actual and/or potential abuse not being investigated in a prompt and/or thorough manner.	F9999		

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F9999	Continued From page 82 The allegations of abuse are as follows: A) 1 incident of mental abuse involving unknown staff against R12. B) 2 incidents of E3's pulling R5's hair. C) 1 incident of involuntary seclusion of residents in a room for an extended period of time while the floor was being waxed and not allowing the residents to go to the restroom or to bed. These residents are: R4, R17, R26, R27, R28, R29, R30 and R39. D) 1 alleged incident of physical abuse against R31 by E23. E) 1 incident of an alleged sexual assault against an unknown resident by E23. The facility staff also failed to report allegations of abuse per the facility policy to the Illinois Department of Public Health and the police. The facility administrative staff did not follow their policies and procedures on abuse in that the Director of Nursing did not report allegations of abuse to the Administrator who is the abuse coordinator. The facility administrative staff did not implement preventive measures per the facility's policies and procedures to protect the 141 in-house residents from actual and/or potential abuse. The findings include: 1. Review of the abuse current policies and procedures for this facility document that "The Administrator serves as the Abuse Prevention Coordinator and is responsible for the	F9999		

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coordination of investigations into allegations of abuse or neglect. The Administrator may designate other administrative personnel to assist in the efforts of the program/investigation. It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately." and "All allegations of resident abuse, regardless of the source of abuse, will be fully investigated to prevent further incidents."

The investigation protocol documents that the facility staff shall investigate any occurrence, notify Public Health within 24 hours of reporting, and submit a written report within 5 business days.

E1, Administrator, stated during an interview on 8-20-06 that abuse training is done during the initial training process and through yearly inservice training.

2. An allegation of mental abuse was reported to E17, Certified Occupational Therapy Aide, on 07-06-06 by R12. E17 reported this allegation to E2, Director of Nurses, immediately. No investigation was initiated until 07-09-06. This was verified by E17 and E2.

R12's social service notes were reviewed on 8-17-06. A Nursing Progress note dated 07-09-06 and written by E18, Resident Coordinator/Chaplain, document the following. "Writer and Res (Resident) went to Res room alone and writer asked res about what happened two nights ago. At first Res did not want to say anything and explained I was there to help him. He said two men came in and raised his mattress up and put some wedges under it and made him

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lay in a position that he said if I lay like this very long, it starts hurting my back and told CNAs (Certified Nursing Aides) this. CNA1 came back in stating 'I wish you would die'. Res asked him why would you say that to me, I never did or said anything to hurt you. CNA1 repeated it and left the room....Asked Res to describe the CNAs. Said both male. CNA1 was little, short with straight hair and glasses. CNA2 was heavy, big person and went along with CNA1....Asked if this was the only time. Res first said it happened one other time, then later in conversation, said it happened 3 or 4 times, maybe more. Res cried various times during the conversation, afraid and stated that CNA1 will probably get even with him. Res toward the end of our conversation said that CNA1 did it to him last night again."

A second social service note dated 07-10-06 and again written by E18 documents two other conversations with R12. The note documents the following: 7-10-06 11:30 am "Resident asked to talk to writer. Resident told writer that the CNA (same one) came in at 3 am and put his hands on my throat and said, 'I hate your God d*** guts.' I told him that he did not work last night, and Resident said, 'I don't care; he was in my room last night.' I looked at Resident's throat and told him his throat is not red or no other signs of someone's hand being on his neck. Resident said he did not press that hard. Resident begins to cry and stated, 'I don't know but to just give up and lose all the progress on my foot.' Writer re-assured resident that giving up is not a good option.....1:45 pm Resident asked to speak to writer again. Went to resident's room and he told me that everyone that was causing him problems were women not men. Writer asked if he was sure and stated 'yes'. Asked if the person that

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F9999	Continued From page 85 was short, little, with straight hair and glasses was a woman and he said 'yes'." E18 was interviewed on 8-18-06 at 11:00 am and indicated that someone in nursing told him about the incident. E18 thought it was after lunch when he talked to R12. He also stated that he gave his first conversation summary to E2 and maybe E14, who was the resident care coordinator at that time. He did not tell E2 about the other conversations but left a copy of the summaries for her. E17, Certified Occupational Therapy Aide, was interviewed on 08-18-06 at 10:00 am and verified the statement that she wrote on 07-06-06 and gave to E2, Interim Director of Nurses, on 07-06-06 immediately after she spoke to E16, Program Director. E17's written statement documents the following. "R12 states 2 male employees at night are being abusive toward him. He states that the males slammed his injured leg into his bed. He also states that a male pushes pillows under his mattress. He states that a male employee told him that he wished that he would die. R12 described 1 of the males as having grey color hair, and the other male as having dark blond hair. On 08-17-06 at 2:30 pm, R12 was interviewed in his room. R12 stated during this interview that 3 CNAs got on to him because he was causing too much trouble by turning on his call light. One of the CNAs told him, "I hate your God d*** guts" and then put her fingers on his throat. R12 stated, "I thought it was a he but it was a she who dressed like a he. She is a big women." He continued to state that now it has settled down. R12 stated that the incidents happened about a	F9999		

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month ago in July. On 08-18-06 at 8:15 am, R12 was interviewed in his room. When asked how these incidents made him feel, R12 stated, "I felt run down, tired, and belittled." R12 also confirmed that he did tell therapy staff, and he thought it was two days before someone came to take to him.

R12's clinical record indicates the following. R12 is an 80 years old resident with diagnoses that includes Parkinson's, Anemia, Bimalleolar Fracture, Fracture of Ankle, and Anxiety. The Minimum Data Set dated 06-22-06 documents that R12 has short term memory problems but no long term memory problems, and has some difficulty in daily decision making in new situations only.

E1, Administrator, stated during an interview on 08-18-06 at 10:10 am that he did not find out about the incident involving R12 until 08-17-06 when Public Health staff told him. E1 also stated that he would expect staff to call him on something like this. E1 is the abuse coordinator.

Interview with E1 on 8-17-06 at 4:25 pm, documents that an investigation had been completed regarding R12 by E2. This investigation only contained statements from E17, E13, Physical Therapy Aide, E14, Assistant Director of Nurses, E23, Certified Nurses Aide, and E18. However, E1 was unaware of the incident or investigation. It was determined without interviews from the resident and all staff who work Side 4 during the identified time period that the allegation could not have been true. E23 was suspended on 7-09-06 while some statements were taken, and a determination was made that it was not even a reportable incident.

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F9999	Continued From page 87 No other interviews were completed even though the CNAs involved were identified as female on 07-10-06. E2, Director of Nursing, was interviewed on 08-18-06 at 10:23 am. E2 stated that she did not find out about the incident until 07-09-06 or 07-10-06 and stated that she did not have any additional information concerning the allegation of abuse against R12. E2 again was asked if she had any statements or additional information. She stated at that time that she would look. E2 returned at approximately 2:00 pm and stated that she had nothing on the allegation. After E1 was told of the seriousness of this allegation at 3:33pm on 08-18-06, he returned at 4:00 pm with statements he had just received from E2. During an interview on 08-20-06 at 9:00 am, E2 stated that she could not remember if she told E1 about the incident regarding R12. E2 went on to state that she usually tells him everything. The facility administration did not investigate this allegation of mental abuse thoroughly as the facility policies and procedures direct them to do which resulted in no added precautions being used to protect R12 and the other residents in the facility. 3. Review of the facility's abuse investigations show an incident dated 3-24-06. The allegation involved E3 (certified nurses aide) pulling R25's hair. The report shows that the incident occurred at 7:30 am on 3-24-06. The nurses notes show that an assessment was done on this confused resident (R25) at 2:00 pm, which failed to identify if there was excessive hair loss, or if R25 was tender to touch to the area where R25's hair was	F9999		

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pulled. The report states that several residents and staff were interviewed. However, the facility administrator (E1) was unable to provide resident interviews. The facility does have interviews with certified nurses aides E3, E4, and nurse E7. E4's interview (witness of abuse) stated that R25 usually screams, but this time R25's scream was different and more intense prompting E4 to inquire through an adjoining room. E4 demonstrated how E5 pulled R25's hair during the interview.

The investigation was conducted by a previous administrator (E5). An interview with E5 on 8-16-06 at 12:10 pm via phone, shows that E5 does not know if he took notes on the interviews and cannot remember any names as to who was interviewed. E5 stated that he determined that there was no abuse after speaking to several residents and finding no patterns or trends. E5 suspected that the two staff had a falling out, but admits that both E3 and E4 denied a falling out. E5 identified that he did not call the police about the alleged assault as he thought they would laugh at him.

The final report dated 3-28-06 identified no findings of abuse. An addendum dated 3-29-06 identified that E4 reported that E3 had done the same act to R25 three to four months prior to 3-29-06. E3 was again sent home. No interviews were available for this investigation. A form to IDPH dated 4-4-06 stated, "Due to the fact that three to four months have lapsed since the allegation was filed, many details of the allegation cannot be validated. The reporting employee stated that she made mention of the incident to her mother who also is an employee (currently on leave of absence) and this was

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F9999	Continued From page 89 validated by phone with this writer and facility DON." An interview with nurse E7 on 8-22-06 at 9:49 am, showed that R25 did not have any lost hair when she checked her. However, E7 did not remember if she checked her at 2:00 pm or earlier. Interview with E30 (mother of E4) on 8-22-06 at 11:00 am showed that E4 had reported to her that she saw E3 abuse R25 twice. E30 stated, she was called on one of the incidents by E31 (previous Director of Nurses) because E4 was so upset she was crying at the facility. Interview with E4 on 8-22-06 at 1:20 pm showed that the first time E3 pulled R25's hair was about a year ago. E4 stated that she told E3 that she should not be pulling R25's hair. E3 responded that R25 won't sit up. E3 included that R25 is tough to do care on. E4 stated that she knows she should have reported the first incident, but she was friends with E3. E4 stated both incidents involving E3 pulling R25's hair resulted in R25 screaming like she was in pain. On the second incident (3-24-06) R25's face was red as E3 was pulling her forward on the toilet. E4 stated that E3 would grab R25 at the top of her head to move her. E3 denied committing abuse and tendered her resignation on 03-29-06 according to the report sent to IDPH dated 04-04-06. Employee file of E3 shows that she started working on 1-17-03. The file fails to show that the facility staff checked E3's previous references. Medical records staff (E25) reviewed the file on 8-20-06 and was also unable to locate	F9999		

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verification of previous employment. A review of the inservices for abuse show that E3 did not attend the only previous inservices on abuse dated 4-4-05. On 8-20-06 at 1:37 pm E25 reviewed the records and confirmed that E3's name was not on the inservice of 4-4-05.

4. The facility resident council meeting communication form dated 7-5-06, shows that residents complained about staff leaving the residents in the activity room until 3:00 am on 6-22-06 while the hall floor wax dried. During the daily status meeting on 8-13-06 at 4:00 pm, E1 initially stated that the facility did not have any abuse/neglect investigations for the team to review. Interview with activity staff member (E6) on 8-14-06 at 9:35 am showed that on 6-23-06, R26 told her that any resident on side II that was up during the evening of 6-22-06, was taken to the activity room and told they could not leave until 3:00AM. R26 described the number of people in the activity room as a "full house." E6 reported that R26 was upset and that he commented that it was an awful long time to have to wait. E6 stated that R4 and R26 reported being very tired due to not being able to go to bed until 3:00 am. E6 reported the above allegation the next day to her supervisor but was not asked for a statement until it was brought up again at the resident council meeting on 7-5-06. E6 stated that E2 (acting Director of Nurses) asked for her statement on 7-6-06.

An interview with R26 on 8-14-06 at 10:55 am, showed that an unidentified certified nurses aide (CNA) told him that he had to stay in the activity room until the floor dried, which was around 3:00 am. R26 believes that staff were in the activity room, and that he thinks staff allowed residents

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to go to the bathroom. R26 stated that a couple of residents asked to go to bed but were denied because the floor was not dry. R26's response to how he felt about having to wait until 3:00 am was that he was not told that it would take so long to go to bed. E2, Director of Nurses, stated in an interview on 8-17-06 at 2:10 pm that staff would have to take residents across the waxed floor in order to take them to the bathroom. E2 did not know why staff would not put residents to bed if they had to cross the wet floor to toilet them, nor why they did not put the residents to bed between application of coats of wax. Review of recently obtained, undated statements from staff (obtained by E1) show that the residents who were kept in the activity room also included R27, R28, R29, and R30. E29 (CNA) wrote in a statement, "...patients taken to bathroom on side 2 shower room between coats of wax - staff were with residents 1:1 and able to go back to bed after waxing completed-patients in activity room for own protection so they would not get up and fall on wax floors-one patient rested in recliner."

E1 stated on 8-14-06 that this issue was not considered abuse or neglect. A review of the facility matrix and tour notes of 8-13-06 show that R27, R28, R29, and R30 are all confused residents.

Interview with E28 (CNA) on 8-22-06 at 1:50 pm showed that she was one of the staff members that was in the activity room during the floor waxing of 6-22-06. E28 stated that there were about 7 or 8 residents put in the activity room. E28 stated that the staff could not even go to answer call lights while the floor was drying. E28 stated that if the people doing the floor were near the room where a call light was going off, they

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SHAWNEE CHRISTIAN NURSING CTR	1901 13TH STREET HERRIN, IL 62948

(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
F9999	Continued From page 92	F9999		

would answer the call light, otherwise they had to wait until the floor dried which was approximately an hour to an hour and a half. E28 remembered only a few call lights going off, but one unknown resident who had to wait a long time was upset. E28 confirms that R17 and R39 were the residents who wanted to go to bed and were told that they would not be allowed to. The residents reaction was described as aggravated and agitated. E28 stated that if someone in the activity room wanted to go to the bathroom, they would have to wait until the coat of wax dried or use a bed pan. E28 stated that they used a bed pan a few times. E28 stated that two of the residents were allowed to use temporarily placed beds, and two residents were in recliners. E28 remembered starting to put people to bed around 1:30 am, and was finished around 2:30 am. E28 stated the floor waxing extended from room 26 to room 44. A review of the roster shows that 34 residents reside between the rooms of 26 and 44.

5. E1 was told on 08-14-06 at 4:00 pm by IDPH staff of an allegation of sexual abuse to an unknown resident. E1 was told at that time of an allegation of sexual abuse occurring on 07-29-06 at 1:45 pm in the side two shower room. The allegation was slipped under the door to the room where the surveyors were working by an anonymous source on that date.

On 08-19-06 at 9:45 am, E1 was given further information concerning this incident. E1 was told that E15, former housekeeper, stated during an interview on 08-18-06 at 5:15 pm that she overheard two female nurses in the smoke area talk about a sexual abuse. E15 stated that she heard two female nurses discussing the sexual abuse on 08-13-06 a little before the 2:00 pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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shift clocked in. E15 stated that the incident occurred the end of July, 2006 in the side 2 shower room on the midnight shift. The two staff stated that the alleged abuser was E23 and that he fondled an unidentified resident's breast and held his hand over her mouth. On 08-19-06, no investigation had been initiated by the facility. An investigation was started later on 08-19-06.

6. A review of E23's employee file shows a statement by E23 in response to R31's accusations on May 1, 2006. The statement shows that R31 stated that a male staff member beat the hell out of her the night before last. E23 responded that he went to R31's room on Monday night to check her electronic monitoring device placement and function. E23 documented that he tried to explain to R31 what he was doing without success. R31 got upset and began kicking E23 with both her legs. R31 then reached up and started scratching and pinching at E23. E23 writes that he continued to try to explain to R31 without success. E23 returned in 30 minutes and attempted to check R31's bractlet with R31 kicking and striking E23. E23's final charting identified that E23 reported the incident to E24. The nurses notes for R31 for the date of 3-1-06 fail to show that staff conducted a body assessment to identify any injuries.

After surveyor read E23's statement to E24, E24 commented that she does not remember the incident involving R31 accusing E23 of abuse. Interview with E24 on 8-22-06 at 10:30 am, showed that the first time she heard of this incident was this morning. E24 stated that she was surprised that E23 did not come and get her after the first time when R31 was abusive because E23 does usually get assistance with a

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combative resident. E24 stated that if she was told of the incident she would have charted it in the nurses notes. The nurses notes show no entry for April 29th or 30th. E24 stated that no one has asked E24 for a statement in regards to this incident.

Interview with administrator (E1) on 8-20-06 at 11:47 am, showed that he is not aware of the incident as he was not the administrator. At 12:35 am, E1 stated that he and the Director of Nurses looked but were unable to find where an investigation had been completed.

The record does show that R23 was evaluated by a nurse practitioner (Z1) on 3-1-06, which identified the same accusation. R23 was identified as paranoid, but not delusional.

7. A review of the Departments Incident Report file on 8-11-06 verified that these incidents were not promptly and thoroughly investigated and the results were not reported to the Department per the facility policies and procedures.

8. The facility abuse policy documents that the police shall be immediately notified of allegations of abuse. The facility staff did not notify local police of the allegations of mental abuse against R12, the sexual abuse against an unidentified resident on 07-29-06 or 07-30-06, and the physical abuse to R25 when E3 pulled R25's hair.

(A)