STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E866	A. BUILDING ______ B. WING ______	C 02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILL VILLAGE	1010 WEST NORTH STREET GIRARD, IL 62640

(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 Complaint Investigation #0740588/IL27181 F252 Complaint Investigation #0740609/IL27209 F223, F225, F226 and F490 This was a partial extended Survey.	F 000		
F 223 SS=K	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed: 1) to ensure that 13 of 14 residents on the sample, (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R13 and R14), were not physically, verbally or mentally abused. R1's personal items were taken away as a form of punishment. R2's personal body alarm was placed at her ear and set off to punish R2 for getting out of her chair, she was also stuck with the safety pin that secured the body alarm. Staff grabbed at R6's fractured arm causing R6 to cry. R7 was forced to take a shower. R8 was taunted so she would chase staff. R13 was taunted so she would get upset and curse and staff would laugh. Staff restrained R14 by holding his arms behind his back or would bend back his fingers. Staff made fun of R3 by mocking her. Other residents who were abused were R3, R4, R5, R9, R10 and R11.	F 223		3/2/07

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1	F 223		

F 223

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These Failures resulted in an Immediate Jeopardy.

2) to report all alleged incidents involving mistreatment and abuse, including misappropriation of resident property to the administrator of the facility and to other officials in accordance with State Law

3) to thoroughly investigate, and to take steps to prevent further asbuse while the investigations were in progress

4) to implement written policies and procedures that prohibit abuse of residents

5) failed to follow its Policy and Procedure for reporting abuse, neglect and/or theft and Abuse prohibition program

While the Immediate Jeopardy was removed on 2-9-07, the facility remains out of compliance at severity level two, while the facility continues staff education on abuse policy and procedure; abuse prevention; and evaluates staff understanding.

Findings include:

1. Record review of R2's February 2007 Physician Order Sheet (POS) shows R2 is an 86 year old female with a diagnosis, in part, of Alzheimer's Disease and Delusional Disorder. R2's Minimum Data Set (MDS) of 12-8-06 identifies R2 as having severe cognitive impairment. R2's Care Plan of 12-8-06 states R2 has impaired cognition and may not always be able to articulate pain or discomfort; receives Ativan daily for anxiety. Her Care Plan states

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F 223	Continued From page 2 that R2 is at risk for falls, has an unsteady gait and requires assistance of 1 to 2 , hand in hand toward all destinations. A Care Plan note of 12-8-06 shows that R2 has a Personal Body Alarm. A written statement by E3, Unit Aide, dated 1-25-07 states that E3 had witnessed on several different occasions abuse happening on C Hall (Special Care Unit). E3 had seen E4 and E5, Certified Nurse Aides (CNA's) hold R2's body alarm up to her ear while it was going off and tell R2 if she would not keep getting up then they wouldn't do that to her. E3 stated she had seen the CNA's poke R2 with the safety pin that holds the body alarm to R2's wheel chair. They get upset because R2 constantly tries to get up out of her chair and go to the bathroom or to bed. A written statement by E18, employee, of 1-26-07 states that E18 that while she was on the unit, she saw or heard inappropriate conduct towards the residents. It came from the same two CNA's, E4 and E5. One day E18 saw R2 in bed and E5 went in to get R2 up and R2 said, "I don't want to go to school today." E5 told R2 that she didn't go to school that she was an old woman. E4 and E5 have been rough in their manner when R2 gets up and set off her body alarm...all of this has happened in the past 2 to 3 months., A written statement by E10, Activities, dated 1-26-07 states that she has seen R2's pin undone several times. E4 and E5 are not kind to the residents and should not talk to them like that. "I believe E6, Registered Nurse/Unit Manager) is aware of their attitude and sticks up for them. R2 wants to go to bed all the time now. She won't stay up for activities or anything now she just wants to sleep all the time. They put her to bed right after she is done eating and keep her	F 223		

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there. When she is up all they do is say, "Sit Down (R2)" and I never see any one walk with her." E10 stated this abuse had been going on since she had work on the Unit. Interview with E1, Administrator, on 2-20-07 reflected that E10 has worked for the facility since 8-23-06.

A written statement by E11 on 1-25-07 states that she had been told by E3 that E4 and E5 had been very rude with residents and that they would stick R2 with a safety pin.

Confidential interview during the Survey reflected that another staff member, in addition to E3, had seen E4 take off R2's body alarm and set it off at R2's ear saying , "Do you hear how loud that is." Confidential interview stated it was abuse and that E4 and E5 are bullies.

E3 gave a statement to the Police Department on 1-30-06, reflecting the above abuse. E3 stated E4 stuck R2 with the safety pin close to R2's upper buttocks. E5 stuck R2 with the pin on the upper part of R2's back where the safety alarm.

E5 gave a written statement to the Police Department on 1-30-07 stating, "I, E5 have held a body alarm up to R2's ear at least 3 times."

2. Record review of R6's POS of February shows that R6 is a 79 year old female with a diagnosis, in part, of Alzheimer, Dementia, Anxiety and Degenerative Arthritis. R6's MDS shows that R6 is cognitively impaired. Record review of Hospital History &Physical of 7-14-06 shows that R6 had a fractured right wrist due to a fall.

R6's Care Plan of 12-26-06, identifies R6 as being at risk for pain and may not always be able to voice pain/discomfort.

A written statement by E3, Unit Aide, on 1-25-07 states that E5, CNA, grabbed R6's hurt

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arm and asked does this hurt, does this hurt, does this hurt? R6 barely manages to say anything clearly, she mumbles a lot but she was so upset she said, "DDD Don't. Don't. Don't. Don't do that. Do that." She started yelling and mumbling.

On 1-30-07 at 11:02AM, E3 gave a written statement to the Police Department of the above abuse concerning R6. E3 documented that when R6 started to yell, E5 jumped up and away from the table from feeding her and laughed a little bit at getting a rise out of R6. Then E6, RN, looked up and said something to the effect that someone was having a bad day. But E6 had no clue that E5 had jut been grabbing on R6's bad arm that has to be propped up on a pillow.

3. Record review of R1's February 2007 POS shows that R1 is a 62 year old female with a diagnosis, in part, of Dementia and Mental Retardation.

R1's most current MDS shows that R1 has cognitive impairment.

R1's Care Plan of 9-26-06 states that R1 needs much encouragement to eat with approach to substitute with foods she likes for dislikes. Care Plan states that R1 has slurred speech which makes it difficult for staff to understand and difficult for her to express her needs. Care Plan states R1 may display behavior of resisting care, she may argue with staff, cry and pout and refuse care.

A written statement by E10, Activities, on 1-26-07 states, "I don't like the way that they punish R1 by taking her things away from her that is just not right." Referring to E4 and E5. E10 stated she did not know what happened to R1's medals they have been gone for some time now. E10 documented that R1's personal items

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F 223	Continued From page 5 are taken from her as punishment. Written statement from E21, housekeeping, dated 1-26-07 states she has witnessed E4 and E5 being rude to R1, taking R1's personal belongings and put them up to control her behavior. A written statement by E7, Licensed Practical Nurse, on 1-25-07 states E4 and E5 are sometimes rough on R1 by treating her like a child saying you need to sit down and eat. When she complains they will tell her there is no reason why your can't eat. dietary uses a better approach by trying to get her something else...they refuse to give a sub when she did not want what was being served. Interview with E8, Social Service Director, on 2-15-07 at 2PM, E8 stated that staff would take items from R1 to get her to do things. E8 stated that's what they do at her school and the facility was trying to be consistent with school Care Plan. E8 stated she didn't realize that the facility should not be taking R1's personal items away from her and they are no longer doing that. E8 states that R1's medals were locked up in her office. E8 stated she had been off work for an extended time and did not know when R1 got her medals back. 4. Record review of R13's MDS of 9-19-05 identifies R13 as being a 83 year old female with a diagnosis, in part, Dementia, Agitation and Psychosis. R13's MDS shows that R13 has severe Cognitive impairment. R13 has behaviors of being verbally abusive that is not easily altered. R13 needs supervision with walking in the corridor and with locomotion on the unit. R13's Care Plan of 1-23-07 states that R13's gait may be unsteady at times due to confusion/agitation. Care Plan states that R13	F 223		

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has a stuffed dog she calls Pepper. Agitation is noted to significantly and immediately diminish when given stuffed animal.

During a confidential interview during the Survey, a statement was given that R13 has a stuffed animal called Pepper. R13 used to have a dog named Pepper and she thinks the stuffed dog is Pepper. She thinks he is real. E4 was observed to walk down the hall behind R13 and tap her on the shoulder and move out of the way so when R13 turned around there wasn't anyone there. E4 would then get behind R13 and tap her on the other shoulder and quickly move so that when R13 turned around there wasn't anyone there. R13 would then cuss saying, "G-- D--- stop that!" E6, Registered Nurse, saw E4 and E5 and told them to quit. It happened the end of December or beginning of January of this year. E4 and E5 would go bark at R13 and R13 would cuss at the dog for barking. E4 and E5 would laugh. This was all reported to E1, Administrator and E3, Care Plan Coordinator, at the time in December 2006 or January 2007.

5. Record review shows that R14 is deceased.

R14's MDS of 7-18-06 shows that R14 was a 54 year old male with a diagnosis, in part, Cerebrovascular Accident, Schizophrenia, Non Psychotic Brain Syndrome and Depression. R14 had severe cognitive impairment.

R14's Care Plan of 7-18-06 stated R14 could be physically aggressive towards staff and if agitated, approach again later or try different staff member. Care Plan stated that R14 had a safety net bed and required assistance in and out of the bed.

Written statement by E10, Activity Aide, on 1-26-07, E10 stated she hated the way E4 and E5 kept R14 locked up all the time in that thing.

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F 223	Continued From page 7 He never got out when they were working. Written Statement by E11, CNA, on 1-25-07 states that she heard that R14 had his fingers bent back and taking the food tray away from him. E11 stated she had heard other CNA's talk about how E4 and E5 bent back R14 fingers back and held his arms behind his back. Interview with E11, CNA, on 2-15-07 at 2:20PM, reflected that one of the nurses, E7 or E14, had asked her to assist R14 with eating. The nurse stated that he may be a little agitated because E4 ripped the tray from R14. E11 stated that E4 would get behind R14 and hold his arms behind his back when he was agitated. 6. Review of employee statements of 1-25-06, 1-26-07 and 1-27-06 show allegations of abuse to other residents. On 1-27-07, E20, CNA, wrote a statement that she had worked over to 12 noon and saw that R14 and R7 were not fed breakfast. E3, Unit Aide, wrote a statement on 1-25-07 stating, E4 and E5 would make residents take a shower even if they didn't want to. E5 made R7 take a shower and she was crying and ran out of the shower room naked and E3 had to be the one to get R7 covered up and try to calm her. "E5 was using that same laugh, you know the one she uses when she is trying to get a rise out of someone. R7 was crying the whole day and didn't want to get near E5. In a written state to the Police Department of 1-30-07, E3 confirmed the shower incident with R7. E3 stated that E4 and E5 manhandled R9, not hardly ever trying to talk to her. They just tell the residents what to do. E4 and E5 have picked on R8 getting her to the point where she tries to chase them and she can barely walk. They laugh and think it's funny.	F 223		

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On 1-26-07, E18, Activity Aide, wrote a statement that E4 and E5 are rough with R8 when she removes her body alarm.

Written statement by E21 on 1-26-07 states E21 had witnessed E4 and E5 being rude to R10 and R11...They talk about residents in front of them.

E10 wrote a statement on 1-26-07 that states that E10 had witnessed inappropriate actions by E5 towards R3 by arguing with R3 as to why she is here at the facility. Nurses Note of of 1-14-07 states, "R3 anxious @ Supper. Appetite poor. R3 states she is worried about the people who work here, believes they are here to hurt her..."

E10 had witnessed E5 shove R11 into his room. R4 was left in his room all day without much care.

Interview with Z4 (Police Sergent) on 2-8-07 at 6:30PM confirmed that Z4 had done an investigation of abuse at the facility. Z4 stated that E5 had written a statement confirming she abused R2. Z4 stated he had talked to E3, E4 and E5. Z4 stated that E4 and E5 are bullies. Z4 stated he determined in his investigation that there was elder abuse at the facility.

On 2/9/07 the Immediate Jeopardy was identified to have begun on 8-23-06 when interviews indicated residents were being abused. E1, Administrator and E2, Director of Nursing were notified of the Immediate Jeopardy on 2-9-06 at 2:30PM.

The facility took the following steps to remove the Immediate Jeopardy:

1. 1/25/07- Staff that were alleged to be involved were suspended and an investigation was

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F 223	Continued From page 9 initiated. 2. 1/25/07 - Illinois Department of Public Health and local police were notified. 3. Upon substantiation the 3 staff members were terminated on 2/6/07. 4. 1/26/07 - All staff were given a copy of the facility's abuse policy and reminded of their responsibility to report. 5. 1/29/07 and 2/2/07 all staff were inserviced regarding facility abuse policy. 6. During the investigation an allegation was made against 3 additional CNA's, and they were suspended on 2/9/07. 7. No staff will be allowed to work if there has been an allegation of abuse made against them.	F 223		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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	F 225		3/2/07

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F 225	Continued From page 10 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 observation and interview, the facility failed to report all alleged incidents involving mistreatment and abuse, including misappropriation of resident property to the administrator of the facility and to other officials in accordance with State law. The Facility failed to thoroughly investigate, and to take steps to prevent further abuse while the investigations were in progress for 13 of 14 residents on the sample, R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R13 and R14, who were alleged to be physically, verbally or mentally abused. This failure resulted in an Immediate Jeopardy.	F 225		

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While the immediacy was removed on 2-9-07, the facility remains out of compliance at severity level two, while the facility continues staff education on abuse policy and procedure; abuse prevention; and evaluates staff understanding.

Findings include:

1. Residents that were abused physically, verbally and/or mentally include:
A. R1's personal items were taken away as a form of punishment.
B. R2's personal body alarm was placed at her ear and set off to punish R2 for getting out of her chair and R2 was stuck with the safety pin that secured the body alarm.
C. Staff grabbed at R6's fractured arm causing R6 to cry.
D. R7 was forced to take a shower.
E. R8 was taunted so she would chase staff.
F. R13 was taunted so she would get upset and curse and staff would laugh.
G. Staff restrained R14 by holding his arms behind his back or would bend back his fingers.
H. Staff made fun of R3 by mocking her.
I. Other residents who were abused were R4, R5, R9, R10 and R11.

2. According to the incident report dated 1/25/07, "a unit aide (E3) reported alleged misconduct by 2 C.N.A.'s (Certified Nurses Aides) working on our Dementia Special Care Unit." The allegation named E4 and E5, CNA's, as the alleged perpetrators. However, interview with E3 on 2/9/07 indicated she had attempted to tell facility staff about inappropriate treatment of residents on the Alzheimer's Unit in December and early in January with no results and had told E1 (Administrator) of an incident of E5 grabbing a

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(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 resident by the arm the day before (1/24/07). Review of the Police report dated 1/30/07 indicates she reported that CNA's behaviors started to "cross the line" sometime after Thanksgiving. According to E1, Administrator (Adm.), on 2/9/07 at 8:30am, she had not been informed of any allegations of abuse on the special care unit prior to 1/25/07. Confidential interview confirms E3's statement that E1 was notified prior to 1/25/07. Confidential interview states two incidents were witnessed late December, early January that involved mistreatment of R13 when E4 and E5 were observed tapping R13 on the shoulder repeatedly then jumping to the other side until she got upset. R13 carries a stuffed dog and both CNA's were observed barking at her until she got angry and cussed at the dog then laughed at her. According to the confidential interview, E6, RN (Registered Nurse) also observed this behavior and told the CNA's "you girls quit it!" but did not do anything to prevent this behavior from occurring again. These incidents were reported to E1 and E12 (Care Plan Coordinator/MDS) immediately also after they occurred but no investigation occurred nor were either CNA removed from care giving to prevent further incidents of abuse. Another confidential interview also indicates that E1 and past DON's (Director of Nurses) were informed that frustrations were high on the unit and concerns with staff "getting short" with the residents was reported. This also resulted in no investigation or corrective action being taken to prevent further incidents of abuse. Review of staff statements done during the	F 225		

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	14E866	A. BUILDING ______ B. WING ______	C 02/21/2007

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F 225	Continued From page 13 investigation of 1/25/07 also indicated other staff were aware of the abusive behavior of staff toward residents. E10's states "I believe that the floor nurse (E6) is aware of their attitude and sticks up for them. They (E4 and E5) are just not kind to the residents and they should not talk to them like that." There is no evidence that E10 ever reported this behavior even though she felt it was inappropriate. When E17 was asked if she ever witnessed abusive behavior, she stated "no not physical they are getting the right care as far as I know but it all seems abusive because they can't get their personals. I hear things behind closed doors but couldn't tell you who I have heard say what things especially when I work days. Just don't like working around the patients it upsets me. so I keep to myself that is why I stay and keep my work done. I hear gossip and I don't get into it with them." Again, there is no indication E10 ever reported these behaviors to the Administrator even though she may have felt was inappropriate. E11, CNA, stated on 2/15/07 at 2:20pm, that she observed E4 holding R14's arms behind his back when he was combative. E4 stated she did not report this to anyone including the Administrator although she felt it was not right. E7, LPN (Licensed Practical Nurse) when asked if she had witnessed abuse stated "verbal or the tone of the voice in the way they approach the residents at the time. E4 and E5 can be like this at times. When stress levels are high and for instance R2 won't sit down, they may yell loudly sit down. Sometimes they may be rough on R1 by treating her like a child saying you need to sit down and eat. When she complains they will tell her there is no reason why you can't eat. Dietary uses a better approach by trying to get her	F 225		

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F 225	Continued From page 14 something else. With R12 they tell him come on you can get up when he is being difficult. When I hear these things I speak up and tell them not to do it or remind them that is not right. I think they all need to go to a unit and observe approached. you get a lot further with sugar than you do with vinegar. They deserve to be treated like human beings..." When asked about inappropriate approaches, E7 responds "Its all verbal. I don't believe they realize that they are even doing it. If you put a tape recorder down there you would be shocked at what you hear." In addition, E7 stated "I have witnessed at times when the stress level is high that E4, E5, E19 and E20 yelling residents during care, for example yelling at a female resident to sit down, several times, and pulling resident up in his chair several times, refusing to give a female resident sub when she did not want what was being served 6p - 6a CNA's often yell at residents to go to bed or sit down." The written statement from E18, CNA, also indicates abusive behaviors towards residents and that "all of this has happened in the last two or three months" which verifies E3's initial statement. However, no indication that the Administrator was notified until 1/25/07. Interview with E3 on 2/9/07 at 3:30pm also indicated she had reported staffs abusive behaviors to E8, Social Service Designee (SSD) between December and January and that E8 was known to have residents personal belongings in her office which is on the unit. E8 stated on 2/15/07 at 9:10am that she spends approximately about 10% of her time on the unit and is responsible for making sure residents In E7's written statement from the facility and	F 225		

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F 225	Continued From page 15 provided to the police, E7 identified 4 CNA's, E4, E5, E19 and E20, yelling at residents during care, yelling at a female resident to sit down and pulling a resident up in his chair several times. She also indicates they refused to give a female resident a food substitute when she did not want what was being served and on 6p - 6a shift, CNA's "often yell at residents to go to bed or sit down." Also, according to E19 and E20's statement, E13, CNA, was alleged to have called a resident an "idiot." 3. According to the investigation provided by E1, only 4 individuals were identified as "alleged perpetrators" and did not include E19, E20 or E13 even though statements obtained from E7, E19 and E20 had identified them as being abusive. On 2/9/07 at 1:07pm, E1 stated she suspended 4 individuals after the allegation was made on 1/25/07. E1 also stated she suspended E19 and E20. However, when the personnel files of these two individuals were reviewed, a note stating they were "removed from unit-special care pending an investigation" was noted to be in their personal records. E1 was asked for clarification and stated the CNA's were not suspended but reassigned to work on other halls in the facility. E13 was not suspended or reassigned and remained on the special care unit. The facility failed to prevent potential further abuse by allowing E19, E20 and E13 to continue have contact with the residents until such time that an investigation was concluded. The three CNA's were suspended on 2/9/07 pending the investigation results. 4. The facility failed to ensure that the results of the investigations were reported to other state officials in accordance with State law within 5 working days of the incident. According to E1 on	F 225		

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F 225	Continued From page 16 2/20/07, the results of the investigation was faxed to IDPH on 2/9/07 at 4:57pm. This time frame exceeds 5 working days. On 2/9/07 the Immediate Jeopardy was identified to have begun on 8-23-06 when interviews indicated residents were being abused. E1, Administrator and E2, Director of Nursing were notified of the Immediate Jeopardy on 2-9-06 at 2:30PM. The facility took the following steps to remove the Immediate Jeopardy: 1. 1/25/07- Staff that were alleged to be involved were suspended and an investigation was initiated. 2. 1/25/07 - Illinois Department of Public Health and local police were notified. 3. Upon substantiation the 3 staff members were terminated on 2/6/07. 4. 1/26/07 - All staff were given a copy of the facility's abuse policy and reminded of their responsibility to report. 5. 1/29/07 and 2/2/07 all staff were inserviced regarding facility abuse policy. 6. During the investigation an allegation was made against 3 additional CNA's, and they were suspended on 2/9/07. 7. No staff will be allowed to work if there has been an allegation of abuse made against them.	F 225		
F 226 SS=K	483.13(c) STAFF TREATMENT OF RESIDENTS	F 226		3/2/07

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F 226	Continued From page 17 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 interviews and record reviews, the facility failed to implement written policies and procedures that prohibit abuse of residents The facility failed to implement their abuse prohibition policy by prompt investigation on allegations and removal of all employees in question from resident contact pending the investigation, failed to provide new employees with an extensive overview of all abuse policies and forms, failed to provide information and training to residents and families, and failed to immediately report the matter to the resident's representative. This failure resulted in an immediate jeopardy. While the Immediate Jeopardy was removed on 2-9-07, the facility remains out of compliance at severity level two, while the facility continues staff education on abuse policy and procedure; abuse prevention; and evaluates staff understanding. Findings include: 1. Residents that were abused physically, verbally and/or mentally include: A. R1's personal items were taken away as a form of punishment. B. R2's personal body alarm was placed at her ear and set off to punish R2 for getting out	F 226		

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F 226	Continued From page 18 of her chair and R2 was stuck with the safety pin that secured the body alarm. C. Staff grabbed at R6's fractured arm causing R6 to cry. D. R7 was forced to take a shower. E. R8 was taunted so she would chase staff. F. R13 was taunted so she would get upset and curse and staff would laugh. G. Staff restrained R14 by holding his arms behind his back or would bend back his fingers. H. Staff made fun of R3 by mocking her. I. Other residents who were abused were R4, R5, R9, R10 and R11. 2. Review of the facility's policy REPORTING ABUSE, NEGLECT AND/OR THEFT indicates the facility will ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of a resident's property are reported immediately to the Administrator and/or his/her designee and to other officials in accordance with state law. The policy continues to state the facility will provide evidence that all alleged violations are thoroughly investigated and will prevent further abuse while the investigation is in progress. The policy also indicates that the results of all investigations will be reported to the Administrator or his/her designated representative and other officials in accordance with State Law within 5 working days of the incident, and if the alleged violation is verified, appropriate action will be taken. The "ABUSE PROHIBITION PROGRAM" under PROTECTION states that "In the event that an allegation of abuse is made against an employee, that employee will be removed from any and all situations where contact with the resident can	F 226		

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F 226	Continued From page 19 occur, and until such time that an investigation is concluded." A. The facility failed to ensure that all allegations of abuse are immediately reported to the Administrator and that those allegations resulted in an immediate investigation and removal of staff to avoid contact with residents. According to the incident report dated 1/25/07, "a unit aide (E3) reported alleged misconduct by 2 C.N.A.'s (Certified Nurses Aides) working on our Dementia Special Care Unit." The allegation named E4 and E5, CNA's, as the alleged perpetrators. Interview with E3 on 2/9/07 indicated she had attempted to tell facility staff about inappropriate treatment of residents on the Alzheimer's Unit in December and early January with no results and had told E1 (Administrator) of an incident of E5 grabbing a resident by the arm the day before (1/24/07). Review of the Police report dated 1/30/07 indicates she reported that CNA's behaviors started to "cross the line" sometime after Thanksgiving. According to E3, on 1/25/07 she told another CNA who took her to talk with E12, ADON (Assistant Director of Nursing). E3 stated a report was then filed on 1/25/07. According to E1, Administrator (Adm.), on 2/9/07 at 8:30am, she had not been informed by E3 of any allegations of abuse on the special care unit prior to 1/25/07. Confidential interview confirms E3's statement that E1 was notified of inappropriate behaviors of staff to residents prior to 1/25/07. Confidential interview states two incidents were witnessed late December, early January that involved mistreatment of R13 when E4 and E5 were observed tapping R13 on the shoulder repeatedly	F 226		

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F 226	Continued From page 20 then jumping to the other side until she got upset. R13 carries a stuffed dog and both CNA's were observed barking at her until she got angry and cussed at the dog then laughed at her. According to the confidential interview, E6, RN (Registered Nurse) also observed this behavior and told the CNA's "you girls quit it!" These incidents were reported to E1 and E12 (Care Plan Coordinator/MDS) immediately after they occurred but no investigation occurred nor were either CNA removed from residents contact per their policy. Another confidential interview indicates that E1 and past DON's (Director of Nurses) were informed that frustrations were high on the unit and concerns with staff "getting short" with the residents was reported. This also resulted in no investigation. Review of staff statements done during the investigation also indicated additional staff were aware of the abusive behavior of staff toward residents. E10's states "I believe that the floor nurse (E6) is aware of their attitude and sticks up for them. They (E4 and E5) are just not kind to the residents and they should not talk to them like that." There is no indication E10 ever reported this behavior to the Administrator even though she felt is was inappropriate. When E17 was asked if she ever witnessed abusive behavior, she stated "no not physical they are getting the right care as far as I know but it all seems abusive because they can't get their personals. I hear things behind closed doors but couldn't tell you who I have heard say what things especially when I work days. Just don't like working around the patients it upsets me. so I keep to myself that is why I stay and keep my work done. I hear	F 226		

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F 226	Continued From page 21 gossip and I don't get into it with them." Again, there is no indication E10 ever reported staff behavior she may have felt was inappropriate. E11, CNA, stated on 2/15/07 at 2:20pm, that she observed E4 holding R14's arms behind his back when he was combative. E4 stated she did not report this to anyone but identified it as not being right. E7, LPN (Licensed Practical Nurse) when asked if she had witnessed abuse stated "verbal or the tone of the voice in the way they approach the residents at the time. E4 and E5 can be like this at times. When stress levels are high and for instance R2 won't sit down, they may yell loudly sit down. Sometimes they may be rough on R1 by treating her like a child saying you need to sit down and eat. When she complains they will tell her there is no reason why you can't eat. Dietary uses a better approach by trying to get her something else. With R12 they tell him come on you can get up when he is being difficult. When I hear these things I speak up and tell them not to do it or remind them that is not right. I think they all need to go to a unit and observe approaches. you get a lot further with sugar than you do with vinegar. They deserve to be treated like human beings..." When asked about inappropriate approaches, E7 responds "Its all verbal. I don't believe they realize that they are even doing it. If you put a tape recorder down there you would be shocked at what you hear." In addition, E7 stated "I have witnessed at times when the stress level is high that E4, E5, E19 and E20 yelling residents during care, for example yelling at a female resident to sit down, several times, and pulling resident up in his chair several times, refusing to give a female resident sub when she did not want what was being served 6p - 6a	F 226		

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F 226	Continued From page 22 CNA's often yell at residents to go to bed or sit down." The written statement from E18, CNA, also identifies abusive behaviors towards residents and that "all of this has happened in the last two or three months" which verifies E3's initial statement that the abusive behavior was ongoing. Interview with E3 on 2/9/07 at 3:30pm also indicated she had reported staffs abusive behaviors to E8, Social Service Designee (SSD), between December and January and that E8 was known to have residents personal belongings in her office which is on the unit. E8 stated on 2/15/07 at 9:10am that she spends approximately about 10% of her time on the unit and is responsible for making sure residents have everything they need and to communicate with families. E8 also stated completes the MDS sections on Mood and Behavior and sets out behavioral tracking sheets. E8 recalled E3 telling her she was glad when she was on the unit because things run more smoothly but E8 acknowledged that she didn't ask E3 what she meant and didn't take "any stock" in the comment. E8 also stated there were elevated behaviors on the unit in the last quarter which she attributed to residents being in different stages of the Alzheimer's Disease and at different care levels. When asked if the increase behaviors identified could be the result of abusive behaviors from staff to residents stated "guess it would, but just didn't think of it at the time." B. The facility failed to identify other alleged perpetrators and failed to remove these employees from any and all situations where	F 226		

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F 226	Continued From page 23 contact with the residents can occur, and until such time an investigation is concluded according to their policy. In E7's written statement from the facility which was provided to the police, E7 identified 4 CNA's, E4, E5, E19 and E20 as yelling at residents during care, yelling at a female resident to sit down and pulling a resident up in his chair several times. She also indicates they refused to give a female resident a food substitute when she did not want what was being served and on 6p - 6a shift, CNA's "often yell at residents to go to bed or sit down." Also, according to E19 and E20's statements, E13, CNA, was alleged to have called a resident an "idiot." According to the investigation provided by E1, only 4 individuals were identified as "alleged perpetrators" and did not include E19, E20 or E13 even though statements obtained from E7, E19 and E20 had identified them as being abusive. On 2/9/07 at 1:07pm, E1 stated she suspended 4 individuals after the allegation was made on 1/25/07. She stated she also suspended E19 and E20 when asked. However, when the personnel files of these two individuals were reviewed, a note stating they were "removed from unit-special care pending an investigation" was noted to be in the record. E1 was asked for clarification and stated the CNA's were not suspended but reassigned to work on other halls in the facility. E13 was not suspended or reassigned and remained on the special care unit. The facility failed to follow their policy to immediately remove staff from any and all situations where contact with the resident can occur until such time that an investigation is concluded. The three CNA's were suspended on 2/9/07.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 24 3. Review of the facilities ABUSE PROHIBITION PROGRAM reflects under TRAINING AND PREVENTION that "A. The orientation of all new employees will include an extensive overview of all abuse and neglect policies and forms.", "D. At least one resident meeting per year will have a staff presentation regarding the abuse and prohibition program.", "E. At least once yearly, a formal effort will be made to provide families of residents with information/education about the abuse prevention program with particular emphasis on reporting policies and procedures and feedback mechanisms." Interview with E16, RN, Risk Manager, on indicated that new employees are provided information to read when hired and then complete a pre-test. E16 then stated the new employees are given intense training on abuse during the 8 hours of orientation training. E16 indicated she devotes about 20-30 minutes of the 8 hour training session specifically to Abuse. The policy indicates the facility will provide an "extensive overview of all abuse and neglect policies and forms". A. Interview with several staff members including new employees indicate the training is not an extensive overview but an opportunity to read information and take a test. On 2/9/07 ay 12:55pm, E14, LPN (Licensed Practical Nurse) stated her training included information they read followed by filling out a test. E15, CNA, stated on 2/9/07 at 3:05pm that they are provided information to read then they take a test. E15 added that it is usually done on pay day and you have to complete the information before you get your paycheck. She also stated she had to watched a movie which they would have to put on "pause" as they were watching it during work hours and need to go back on the floor and	F 226		

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PLEASANT HILL VILLAGE	**1010 WEST NORTH STREET GIRARD, IL 62640**

(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 25 provide care. E13, CNA, who started at the facility in September 2006, stated she attended an 8 hour seminar, watched a DVD, then took a test. E7, LPN, stated on 2/15/07 at 10:10am, that she was last trained following the allegations in January. She stated she was given a pink folder to read, sign and then test. E7 also stated this was done on payday. She stated she was unable to read all the information in a short amount of time and took the information home. Review of E3's (CNA) statement to police dated 1/25/07 indicates she added "I have read the abuse prevention papers and policies now" to the end of her report. On 2/9/07 at 3:45pm when questioned about this, stated she had been given the abuse information when she was hired and then signed a paper that she had received them. However, she indicated that she did not have time to read all the information presented at the time and didn't read it until after the allegations were made. The facility failed to provide an extensive overview of the Abuse protocol according to their policy. B. The facility failed to ensure that at least one resident meeting per year will have a staff presentation regarding the abuse and prohibition program. Review of the Resident's Council minutes failed to reflect any abuse training being provided according to the facility policy. Interview with E8, SSD, on 2/15/07 stated that E16, Risk Manager, does all the Abuse training and would provide this training to the residents and family members. Interview with E8 on 2/15/07 indicated that the facility provided written information to the families and to the residents on Thanksgiving but does not provide a staff presentation on abuse that she knows of. On 2/15/07 at 2:10pm, E1, Adm., stated Abuse education for the resident's is provided during the	F 226		

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F 226	Continued From page 26 Resident Counsel meetings when they review Resident Rights. E22, the Activity Director, stated on 2/15/07 at 2:40pm that the Resident Council selects a Resident Rights each month by randomly picking a number. E22 states she does not recall ever discussing abuse with the Resident Council and is unaware of any staff presentation provided to the residents on abuse. E22 stated that the Ombudsman may have spoken on Abuse in January but she was unsure. C. The facility failed to ensure that at least once yearly, a formal effort will be bade to provide families of residents with information/education about the abuse prevention program with particular emphasis on reporting policies and procedures and feedback mechanisms. On 2/15/07 at 2:10pm, E1 stated families are provided the information on abuse on admission and given information at Thanksgiving. She added that the Ombudsman also covers Abuse with the family council. Interview with Z2, Ombudsman, on 2/15/07 at 2pm indicated that she has never provided any training or education on abuse prevention to the residents or families at the facility. Interview with the Family Counsel President also indicates no information or training has been provided regarding the Abuse Protocol. Interview with Z3, family member, on 2/20/07 at 7:40am indicated that she has not been provided any information on abuse annually but may have been provided information on her mother's admission three years ago. Z3 stated she was unaware of the abuse protocol until this most recent event and would appreciate information/education regarding abuse prevention. The policy states families will be provided this information with particular emphasis on reporting policies and procedures and feedback mechanisms.	F 226		

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Interview with Z1, family member, on 2/15/07 at 12 noon, also indicates he has been provided no information on the Abuse protocol and was unfamiliar with the reporting and feedback mechanism.

Interview with Z4, family representative, on 2/20/07 at 12:50pm indicated the facility has provided no information/education about the abuse prevention program to her knowledge. Z4 stated she didn't understand the process when an allegation of abuse was made and wondered if the staff who were suspended were going to be able to return to work. Z4 stated they visit the facility weekly usually during the day and has seen no misconduct from staff while there.

4. The facility failed to immediately report the matter by telephone or in writing, if unable, to reach by telephone, to the resident's representative. Interview with E1, Administrator, on 2/15/07 at 2:15pm, indicates documentation of family notification is written in the Social Service notes of the residents charts. Several records were reviewed and found to contain no reference to the abuse allegations and E1 was questioned again. E1 then stated families were notified by mail. E1 provided a form letter which was sent to all families who had residents residing on the Special Care Unit. The letter stated that "alleged misconduct" on the Special Care Unit was reported to the Administrator on 1/25/07. There is no indication the facility notified the family representation of each resident who was identified as being abused by staff.

Interview with Z3 on 2/20/07 at 7:40am stated she received the letter regarding staff misconduct but was unaware of any specifics. Z3 stated she was told by E1 that her mother (R8) was not involved in the allegations. According to E3's

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written statement dated 1/25/07, staff were "forceful with her (R8) and she would smack at the chair to get them to stop." E18's written statement dated 1/26/07 indicated E4 and E5 were rough with R8 when she set her alarm off while getting up. As of 2/20/07, Z3 had not been informed of allegations of abuse towards her mother.

Interview with Z4, family member, on 2/20/07 at 12:50pm indicated they were called initially after the allegations then received a letter. However, Z4 stated they were given no specifics as to what actually went on. Z4 stated she would hope if her family member was involved, they would be notified of the details. Z4 stated she asked E1 last week if they were "allowed to know what took place" and was told "no" by E1 as the investigation was not completed yet. According to facility records, the completed investigation was done 2/9/07. Z4's family member was one of the residents identified as being roughly handled while in the shower.

On 2/9/07 the Immediate Jeopardy was identified to have begun on 8-23-06 when interviews indicated residents were being abused. E1, Administrator and E2, Director of Nursing were notified of the Immediate Jeopardy on 2-9-06 at 2:30PM.

The facility took the following steps to remove the Immediate Jeopardy:

1. 1/25/07- Staff that were alleged to be involved were suspended and an investigation was initiated.

2. 1/25/07 - Illinois Department of Public Health and local police were notified.

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F 226	Continued From page 29 3. Upon substantiation the 3 staff members were terminated on 2/6/07. 4. 1/26/07 - All staff were given a copy of the facility's abuse policy and reminded of their responsibility to report. 5. 1/29/07 and 2/2/07 all staff were inserviced regarding facility abuse policy. 6. During the investigation an allegation was made against 3 additional CNA's, and they were suspended on 2/9/07. 7. No staff will be allowed to work if there has been an allegation of abuse made against them.	F 226		
F 252 SS=B	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that the Dining Room/Activity Room is clean with a homelike environment. Findings include: During tour of the facility on 2-9-07 at 8:45AM, it was observed that there were dead bugs on the window sills and on the floor. There was caked in dirt built up in the window tracks. There was built up dirt behind and inbetween the soda machine and the water fountain. The water	F 252		3/2/07

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F 252	Continued From page 30 fountain needed cleaned. On 2-15-07 at 3PM, the bugs were observed to still be on the window sills and caked in dirt was still observed in the window tracks. This was after the facility was informed of concerns on 2-9-07.	F 252		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow its Policy and Procedure for REPORTING ABUSE, NEGLECT AND/OR THEFT and ABUSE PROHIBITION PROGRAM. The facility failed to ensure resident's were not abused; they failed to follow their policy reporting and investigating abuse; and they failed to implementing their abuse policy. This failure resulted in 13 of 14 sampled residents on the Special Care Unit being either mentally, physically and/or mentally abused. This includes, R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R13 and R14. This failure resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 2-9-07, the facility remains out of compliance at severity level two, while the facility continues staff education on abuse policy and procedure; abuse prevention; and evaluates staff understanding. Findings include:	F 490		3/2/07

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F 490	Continued From page 31 1. The facility failed to ensure that 13 of 14 residents on the sample, were not physically, verbally or mentally abused: A. R1's personal items were taken away as a form of punishment. B. R2's personal body alarm was placed at her ear and set off to punish R2 for getting out of her chair and R2 was stuck with the safety pin that secured the body alarm. C. Staff grabbed at R6's fractured arm causing R6 to cry. D. R7 was forced to take a shower. E. R8 was taunted so she would chase staff. F. R13 was taunted so she would get upset and curse and staff would laugh. G. Staff restrained R14 by holding his arms behind his back or would bend back his fingers. H. Staff made fun of R3 by mocking her. I. Other residents who were abused were R3, R4, R5, R9, R10 and R11. 2. The facility failed to ensure that all alleged mistreatment and abuse, were reported to the administrator of the facility and to other officials in accordance with State law. The Facility failed to ensure that all alleged violations were thoroughly investigated, and to take steps to prevent further abuse while the investigations was in progress. The facility failed to ensure that the results of all investigations were reported to other state officials in accordance with State law within 5 working days of the incident and when the alleged violation was verified the appropriate corrective action was taken. Interviews with E3, unit aide; E10, Activities; E11 and E18, CNA's; and confidential interviews indicated administrative staff, including E1, Administrator; E12, Care Plan Coordinator; E8, Social Service	F 490		

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Designee; and a former Director of Nurses were told about E4 and E5, CNA's, abusing the residents at various times prior to the investigation on 1/25/07 and they did not respond. Three staff members were allowed to continue to work during the investigation.

3. The facility failed to implement written policies and procedures that prohibit abuse of residents. The facility failed to implement their abuse prohibition policy by prompt investigation on allegations and removal of all employees in question from resident contact pending the investigation; failed to provide new employees with an extensive overview of all abuse policies and forms; failed to provide information and training to residents and families, and failed to immediately report the matter to the resident's representative. Several staff interviews indicated the abuse training is not an extensive overview but an opportunity to read information and take a test. This test is done on payday and/or during working hours. These interviews included E14, E7, LPN's; and E15, E13,and E3, CNA's.

On 2/15/07, an interview with E8, Social Service Designee, confirmed abuse prevention is not discussed at least yearly with the Resident Council.

On 2/15/07, in an interview with E1, she confirmed that a formal effort was not made to provide families of residents with information about the abuse prevention program.

The Immediate Jeopardy was identified on 2-9-07. The Immediate Jeopardy was began on 8-23-06 when interviews indicate residents were being abused. On 2-9-06 at 2:30PM, E1

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and E2 were informed of Immediate Jeopardy at the facility.

The facility took the following steps to remove the Immediate Jeopardy:

1. 1/25/07- Staff that were alleged to be involved were suspended and an investigation was initiated.

2. 1/25/07 - Illinois Department of Public Health and local police were notified.

3. Upon substantiation the 3 staff members were terminated on 2/6/07.

4. 1/26/07 - All staff were given a copy of the facility's abuse policy and reminded of their responsibility to report.

5. 1/29/07 and 2/2/07 all staff were inserviced regarding facility abuse policy.

6. During the investigation an allegation was made against 3 additional CNA's, and they were suspended on 2/9/07.

7. No staff well be allowed to work if there has been an allegation of abuse made against them.