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	145655	A. BUILDING ______ B. WING ______	C 06/13/2007

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LICENSURE VIOLATIONS

300.1210a)
300.1210a)5)
300.1210b)6)
300.3240a)
300.3240b)
300.3240d)
300.3240e)
300.3240f)

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:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

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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)
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)
f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 9 (R1, R2, R4, R5, R7, R8, R9, R10, R11) of 11 sampled residents, were not physically, verbally or mentally abused. This failure resulted in:
A. R1 was handled roughly by staff during care.

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F9999	Continued From page 24 B. CNA taunted R1 and roommate, R2, to get them to argue and get into physical altercations. CNA would tell R2, who is blind, that R1 was getting in her stuff to cause an altercation between R1 and R2. C. CNA would tell R4, who has repeated requests for assistance to shut up and threaten not to come at all if she doesn't quit asking for help. D. CNA did not tell the nurse of R5's complaints of pain and stated she did not report it because she thought R5 was lying. E. R7 was taunted by staff to tell R8 that she's got a big mouth so R8 would yell. F. R9 complained of being cold and had a jacket on, E11 took the jacket off of her telling her she was not cold. G. Staff taunted R10 so that she would get upset and curse and staff would laugh. H. Staff did not report when they saw R11 transferred roughly. Staff did not report when they heard that another staff hit R11 in the mouth. Findings include: 1. Review of a facility hand written report dated Monday, 5-28-07, indicated that E12, Certified Nurse Aide (CNA) had reported to E1, Administrator, on 5-28-07, that she had a concern regarding E11's (CNA) behavior towards R1 on Sunday evening, 5-27-07. The report documented that E11 was pushing R1 very fast down the hall and took R1 to her room. E12 heard a loud noise and went into R1's room. E12 asked what happened and R1 stated she fell on the bed. E12 stated that E11 appeared upset and E12 stated she would finish caring for R1, and E11 left the room.	F9999		

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F9999	Continued From page 25 The written report states that E1 asked R1 how things are going and R1 said, "fine." R1 denied that anyone had handled her roughly. R1 acknowledged that the other night she almost fell, it was partly R1's fault but she did not get hurt. R1 stated she got her feet tangled. A Report note dated 5-30-07, states that R1 again denied that anyone was ever rough with her. Record review of R1's Minimum Data Set, MDS, of 4-28-07 shows that R1 has diagnoses, in part, Alzheimer Disease, Dementia, Hemiplegia, Seizures, Senile and Presenile Organic Psychoses. The MDS identifies R1 as having moderate cognitive impairment and requires extensive assistance of 1 staff for transfer. The MDS shows that R1 does not ambulate in her room. and requires extensive assistance for dressing, bed mobility, hygiene and toilet use and is totally dependent on staff for bathing. Record review of the investigation report shows that a thorough investigation was not conducted as there was no other staff or residents interviews. An interview with E1 on 6-6-07 at 11:20AM, confirmed that she did not interview any other residents or staff as to whether E11 was rough with residents. E1 also stated that R1's attention span was short. The facility failed to inform the Illinois Department of Public Health of alleged abuse of E11 to R1 within 5 working days of the incident. The allegation was not reported until 6-7-07 after they were informed of concerns on 5/28/07. 2. During an interview with E2, Director of Nursing, on 6-6-07 at 12:05PM, E2 stated on 5-16-07, E2 was called at home and told that staff	F9999		

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F9999	Continued From page 26 went to put R1 to bed and R1 had scratches on her neck and E11, CNA, asked R1 how she got the scratches. R1 said R2 did it. E2 said that R2 has a history of a gun shot wound to the head and is legally blind. E2 stated she asked staff to move R1 to another room for the night to separate the two residents. E2 stated that R1 has now been transferred to another room. E2 stated that R1 has a history of scratching herself and that R2's fingernails were not long enough to cause scratches. E2 stated that the scratches were superficial and now gone. E2 stated she did not do an investigation because by looking at R1 she determined that R1 scratched herself. During confidential interviews with CNA's and Nursing Staff, on 6-6-07 through 6-8-07, 10 of 12 CNA's interviewed and 1 Licensed Practical Nurse stated that R1 and R2 did not get along. The 10 CNA's stated that they had either seen R2 hit R1 in the past or had heard that R2 had hit R1. None of the CNA's reported it. Six of the CNA's stated that they had heard or suspected that E11 would pit R2 against R1 and they would fight. E11 would tell R2 that R1 was getting into her things. E11 would tell R2 to kick R1's ass. None of the CNA's reported it. Interview with E17, Corporate Nurse, on 6-12-07 reflected that R1 and R2 had been roommates since 2-22-07. Record review of R2's MDS of 4-6-07 identifies R2 as having diagnoses, in part, Affective Psychoses, Depressive Disorder, Seizure Disorder, Right Hemiplegia, Dementia and Blind. MDS states R2 has behavior of being socially inappropriate and having moderate cognitive impairment. Nurses note of 6-4-07 states that R2 swung at the	F9999		

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nurse. There is nothing in R2's Social Service Notes of R2 not getting along with R1.

During interview with R2 on 6-7-07 at 10:40AM, R2 stated she had a problem with R1 and would cuss her out. R2 said she did not hit R1. R2 stated if I scratched her with these nails you would not know it. R2 held out her hand and it was observed that R2's nails were not short and she would be able to scratch herself or someone else. Interview with R1 at 10:50AM, R1 stated she did not know how she got her scratches and that one time she hit her head while being put to bed and stated it hurt but not for very long.

3. Record review of R4's MDS of 4-20-07 shows that R4 has diagnoses, in part, Cardiovascular Disease, Osteoporosis, Anxiety, Chronic Obstructive Pulmonary Disease and Depressive Type Psychoses. R4's MDS shows that R4 has moderate cognitive impairment and is socially inappropriate. MDS shows that R4 requires extensive assistance with most ADL's, Activities of Daily Living.

R4's Care Plan of 3-21-07 states that R4 has episodes of repetitive statements and constantly demands the attention of staff above and before all other residents. For example, "Room — needs help, room — needs help. Help me first."

Confidential interview with two CNA's during the Survey, reflected that E11 will tell R4 to shut up or be quiet when R4 has repeated requests for help.

During the Survey, a confidential resident interview reflected that E11 is loud and abusive. She is rough with residents. She is not the type to take care of old people. They can be frail and

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nervous. R4 repeats herself over and over. "I hear E11 say to R4, you don't have to keep hollering if you don't stop, I won't come at all... E11 is a loud mouth bully."

4. Confidential employee interview reflected that E15, CNA, did not report complaints of R5 being in pain and the reason that E15 did not report the pain is because she thought R5 was lying. This was reported to E2, however E15 was allowed to continue to work and there was no investigation.

Record review of R5's Nurse Notes of 6-3-07 reflect that R5's left knee was slightly swollen and X-ray's were negative. Note of 6-7-07 shows that R5 was still complaining of pain and new order for Naprosyn was obtained.

Interview with E15 on 6-7-07 at 1:30PM confirmed that R5 had complained of pain and that E15 failed to report it. E15 stated she thought the previous shift would have reported that R5 was in pain.

Interview with E2 on 6-8-07 at 1:30PM confirmed she was aware of the incident and that she hadn't been able to get to it yet. E15 was suspended with impending investigation into the incident after E1 and E2 were informed of concerns.

5. During an interview with R7 on 6-7-07 at 1:45PM, R7 stated that E11 would instruct resident sto tell R8 that she's got a big mouth and that would cause R8 to yell. Resident states E11 treats me like I'm beneath her and I'm sick of it.

6. Confidential Resident interview reflected that R9 had complained of being cold. Resident stated that R9 is not in her right mind, so the

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resident told staff that R9 was cold and staff got R9 a jacket. Resident stated that E11 came down the hall and asked R9 why do you have that jacket on? I know you're not cold are you cold? R9 finally said "No" and E11 took the jacket off R9 and took it away. The Resident stated, "I know she was cold. E11 bullied her into taking off the jacket."

7. A confidential interview with a CNA indicated that E11 would taunt R10 to get R10 upset and then R10 would cuss and E11 would laugh. E11 did this quite often. She told the nurse, but nothing happened. The CNA stated that E11 did this for entertainment.

Another CNA stated that about 6 months ago, R10 was upset and carrying on. The CNA asked R10 why she was so upset and R10 stated that E11 said R10 sucks d--k. The CNA reported it to the nurse who no longer works at the facility. The CNA stated she asked E11 if she had said that to R10 and E11 laughed. She did not admit it or deny it. The CNA stated she did not know if anything was ever done about the situation but E11 continued to work.

8. Confidential interviews reflect that two CNA's saw E11 roughly transfer R11. One CNA stated E11 threw R11 into the shower chair and did not use a mechanical lift. The CNA stated she told E11 that R11 was going to have bruises from the rough transfer. The CNA stated she did not report the incident. Another CNA stated she saw E11 transfer R11 from her wheel chair to her bed. It was "very rough." One CNA stated she had heard that E11 had smacked R11 in the mouth. The CNA stated she did not know if it was reported and that she was o't going to report

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