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WESTSIDE REHAB & CARE CENTER	**601 NORTH COLUMBIA WEST FRANKFORT, IL 62896**

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F 282	Continued From page 35 indicates R1's bruise could have been obtained when R1 became combative (hitting, kicking, yelling) while E8 (LPN) was attempting to conduct glucose monitoring on early Saturday morning 6/6/09 between 3:30 and 4:00am. The report and related nurses notes of the incident do not indicate the approaches to reduce R1's behaviors were attempted while conducting the blood test. The report indicates the nurse and two CNA's attempted to hold the resident after R1 had indicted verbally and physically that he was refusing the test. 3. Telephone interview with E8 (LPN) was conducted on 6/24/09 at 11:40am. E8 described the incident and did not indicated that any education, coaxing or re-approaching was attempted during the attempted blood test.	F 282		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.3240a) 300.3240b) 300.3240d) 300.3240e) 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility. These written policies shall be in compliance with the Act and all rules promulgated thereunder and shall be followed in operating the facility.	F9999		

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F9999	Continued From page 36 300.1210 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 psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall 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)	F9999		

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F9999	Continued From page 37 These requirements are not met as evidenced by: A. Based on record review, interview and observation the facility failed to ensure that all residents were free of physical and verbal abuse by facility staff. This failure resulted in one resident of five from the sample (R1) being held down for a blood test resulting in bruising and increased aggression and one other resident of the five sampled residents (R4) to be subject to verbal abuse. The staff had knowledge of the physical and verbal abuse and did not implement preventive measures to protect these residents or any of the other 52 residents from actual or potential physical or verbal abuse. B. Based on staff and resident interviews and records reviewed the facility failed to ensure one allegation of physical abuse against R1 and one allegation of verbal abuse against R4 were immediately reported to the administrator of the facility, and one bruise of unknown origin located on R3's neck was thoroughly investigated for the 5 sampled residents. The facility failed to immediately report the allegation of physical abuse to the State Agency as required. The facility also failed to thoroughly investigate the bruising and physical abuse allegations by not including pertinent resident and staff interviews. The abuse incident resulted in R1 being held against his will for the attempted completion of a blood glucose monitoring test resulting in severe agitation, kicking, screaming and a 10cm by 5cm bruise to the abdomen. The second allegation of verbal abuse resulted in stated anxiety for R4 while being cursed by E8. E7 was aware and failed to immediately inform the Administration of	F9999		

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F9999	Continued From page 38 the verbal abuse carried out by E8. The third issue of a bruise on R3 of unknown origin was not tracked to attempt to determine cause. There was a failure to protect the 52 remaining residents from potential abuse by allowing E8 (Licensed Practical Nurse) to continue working scheduled days from the 13th of June until the occasion of the second abuse allegation being made by staff on 6/24/09. C. Based on record review and interview the facility failed to implement their written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. The facility failed to follow established policy for orienting and training employees on how to deal with stress and difficult situations, how to recognize and report occurrences of mistreatment, neglect and abuse immediately, protecting residents involved in identified reports of possible abuse, implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively and filing accurate and timely investigative reports. Failure to operationalize the facility policies allowed the facility not to protect the 52 remaining residents from potential abuse. E8 (Licensed Practical Nurse) was allowed to continue working scheduled days from the 13th of June until the occasion of the second abuse allegation being made by staff on 6/24/09. E6 and E7 who were aware of potential abuse of R1 (6/6/09) and R4 (6/20/09) failed to immediately report the incidents. The facility records and investigative reports document contradictory information about necessary reporting of the events of 6/6/09. E8 reported need for time off to relax and the signs of stress and burnout were not recognized.	F9999		

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F9999	Continued From page 39 The findings include: 1. The admission record for R1 indicates R1 is an 85 year old resident admitted to the facility on 5/2/07 with multiple diagnoses including: Diabetes Mellitus, Diabetic Neuropathy, Hyperlipidemia, Hypertension, History of Myocardial Infarction, and Arthritis. The current Minimum Data Set (MDS), dated 5/22/09, for R1 indicates R1 has modified independence for cognitive skills and good short and long term memory. R1's MDS notes behavioral symptoms of resisting care that are not easily altered. The current care plan for behaviors printed on 6/24/09 for the surveyor indicates a problem defined as "Resident has Hx. refusing care (ie refusing meds, meals, accu-checks, etc.)" The Approaches/Interventions read in part... Attempt to identify cause of resistance and reduce/eliminate if possible - Attempt to coax, but do not force resident - Reapproach at a later time 2. The May 2009 "Skin Tear/Bruise Tracking" form dated 6/6/09 documents for R1: "10pm Bruise noted to abdomen Investigation - Complete - See Report." The "Quality Care Reporting Form" for R1 indicates "date of Occurrence" as 6/7/09, 4:30pm and documents a bruise (no size indicated) found on R1's left mid abdomen. The report form also states the physician was notified on 6/7/09 at 4:45pm, responsible party notified 6/8/09 at 8:30pm. and DON (director of nursing) notified on 6/8/09 at 2:00pm. Interview with E2 (DON) on 6/23/09 at 3:20pm regarding the documentation timing	F9999		

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irregularities found she had instructed the weekend nurse to complete the form and add nurses notes as a late entry after the area was noted and reported on 6/8/09. E2 indicated an investigation of the cause of R1's bruising was conducted. When questioned E2 stated she did not consider this investigation to be an abuse investigation.

Interview with E1 (Administrator) on 6/23/09 at 2:45pm indicated he became aware of the incident from the morning of 6/6/09 on 6/8/09 upon beginning the work day. E1 and E2 were completing an investigation of the bruising, only to determine the cause of the bruise. No reports were made to the State Agency by E1 regarding this incident as it was determined by the completed report and discipline that there was no further investigation needed.

E2 presented an "Investigative Report For Skin Tears/Bruises dated 6/8/09 for review and explanation of bruising to R1. The form indicates a bruise (10cm by 5cm) was noted to the abdomen of R1 during routine daily skin check (no date given). The report finds when R1 was questioned regarding the origin of the bruising R1 stated, "... on Saturday morning when the nurse came into the room to do accu-check, she stuck his finger, resident states he then told the nurse "no, he didn't want her to take his blood, he then began fighting with the nurse. He states then two CNA's came in and they were all around him and he just wanted them to go away. He stated during the incident E7 (CNA) was attempting to hold him and he was sitting on the bed and leaned onto him, states this could have cause the bruise." The report further indicated that statements were taken from all staff members

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present. The report concludes that the staff were counseled for "inappropriate behavior and were disciplined as administration/nursing departments (DON) felt appropriate." The "Supervisor Report of Counsel" found E8 was suspended for three days and was given a written warning for misconduct with a combative resident where resident was noted to have a bruise to the abdomen. The "Report of Counsel" forms for E6 and E7 found they were counseled to "walk away from certain situations to avoid escalating the situation when a resident becomes agitated."

When questioned about the bruise investigation 6/23/09 at 3:20pm E2 indicated that no further statements were taken from any other staff or residents that work with or are cared for by E8. Only E12, E6 and E7 who were on duty at the time of the 6/6/09 incident were interviewed. E2 indicated that she took no statement from R2 who is R1's roommate and was in the room at the time of the incident. E2 felt that E11 (Social Service Director, SSD) may have spoken with R2 about the incident. Interview with E11 on 6/24/09 at 10:15am found he had spoken with R2 but had not documented the interview. E11 stated R2 spoke with him on 6/8/09 and related that he did not want E8 to give him care. R2 stated to E11 that it looked like E8 had held down R1 while attempting to provide him with a blood test on Saturday early morning. Further questioning of E11 found he had written care plans for R1 regarding resisting care including blood glucose monitoring.

Prior to the interview, R2 was identified by facility staff (E3 who was day nurse on 6/23/09) as interviewable and completely reliable. MDS data from 6/8/09 for R2 confirms R2 is independent in

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F9999	Continued From page 42 decision making and has good short and long term memory . An interview with R2, who is the roommate of R1, about the events of the morning of 6/6/09 was conducted on 6/23/09 at 11:45am. R2 related that very early Saturday morning on 6/6/09 the nurse came in to take blood from R1. R2 does not know if R1 was awakened by E8 but R2 was awakened by R1's shouting, kicking and screaming. R2 described the scene as viewed from his bed that is directly across from R1's bed. R2 stated E8 was standing at the side of the bed (West side) and had both her hands on R1's left hand reaching across the bed and R1. The nurse was trying to get blood for a blood test and R1 was kicking and screaming. R2 stated E8 placed her right knee across R1's abdomen to attempt to hold R1. E8 called out for help at this time and one male and one female CNA entered the room to assist E8. R2 stated they pulled the curtain around R1's bed and he could no longer see but could hear R1. R2 yelled out at that time "don't hurt him." R2 said the way R1 was treated "It was wrong." R2 indicated he wished he had paper to document the incident properly. R2 did state he told everyone who would listen about the event. R2 indicated, "I know the law and wanted to call the State Police. R2 said he told the 6/6/09 morning nurse about the event. During this interview R1 was in the room and was asked by R2 to confirm the report of the events from the morning of 6/6/09. R1 was able to recall the events and was willing to show the surveyor the remnants of the bruise on his abdomen and the large tennis ball raised area in the lower left abdomen where the bruising was dissipating. A review of R2's nurses notes confirm on 6/6/09 at 8:00am R2 was, "Awake, lying in bed A- O x3 c/o tx by noc staff. Report to Administrator,	F9999		

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F9999	Continued From page 43 DON...." There were no documented interviews with staff for review. Each staff made written statements regarding the incident of 6/6/09 and are as follows followed by surveyor interviews for each: Neither E8, E6 or E7 indicate in the following interviews they contacted or attempted to contact the Administrator to inform him of the events of the morning of 6/6/09. Further, E7 failed to notify the Administrator of the knowledge of verbal abuse against R4 until the time of the surveyor interview on 6/24/09. E8 statement and interview: The undated written statement prepared and signed by E8 includes the following: "On Sat morning of 6/6/09 I approached R1 to do his accu-check. I woke him et (and) told him what I was doing and stuck his right thumb. Res was moving his hand back and forth and I was trying to get him to hold still so I could retrieve the drop of blood from his thumb. I was telling him "stop R1 and hold still. the worst is over now... let me get this drop." Usually he holds still then but this time he took his fist and punched me in the stomach. It startled me and took my breath and I yelled 'Hey!' CNA's were doing bed check E7 came in the room with E6 close behind. R1 started kicking at us and started to hit me again. E7 stopped his left hand and stopped his left leg from kicking. E6 was telling R1 to 'let her get that R1' at the same time R1 tried to kick E6 and she stopped R1's right leg. I saw R1 was getting more agitated so I said 'Forget it. That's when we all left. The entirety was approx. 1-2 minutes." A surveyor interview was conducted by phone	F9999		

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F9999	Continued From page 44 with E8 on 6/24/09 at 11:40am. E8 indicated she has been employed as an LPN with the facility for 2 years and works the night shift. E8 indicated she believed she had attended abuse training in the past year. When questioned about the incident with R1, E8 stated on the morning of 6/6/09 she began accu-checks on the North hall about 4:00 to 4:30am during the final CNA bedchecks. E8 stated she entered R1's room and uncovered his head (R1 sleeps with blankets over his head because he is always cold). E8 indicated she stated the residents name several times and said she was getting the accu-check now. E8 stuck R1's thumb and the resident called out "Hey" and began to yell and scream. E8 indicated while still holding the thumb/hand she said "hold still won't you let me get this blood." R1 was agitated and yelling "get out of here " "what are you doing" "Don't don't I don't know why you have to do that." E8 stated R1 hit her in the chest and she yelled "Hey." E8 stated R1 usually just fusses at me but does not hit. E8 indicated two CNA's came in the room. E6 held R1 on the right ankle and E7 held the knee to keep R1 from kicking. The event was reported to last 2 minutes tops. According to E8 she felt she had reported the incident to E2 -- she felt she had called her to report it as she thought E2 was on call. When asked, E8 did not remember documenting the call. When asked if R2 who was in the room at the time of the incident, E8 stated that R2 called out not to hurt R1 and that he knew how to take care of this. E8 denied any knowledge of the bruising on R1's abdomen and was unaware of the large tennis ball sized raised area at the site of the bruise.	F9999		

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F9999	Continued From page 45 E8 indicated in the interview that she had spoken to E1 the Sunday before about asking for some time off so she could relax. E8 stated to the surveyor "midnights hard, builds up on you -- stressed out." E8 related during the interview that she received a three-day suspension over the incident. E8 was called Monday and was suspended on Wednesday, Thursday and Friday. E8 stated the time off was a blessing. E6 statement and interview: The undated written statement prepared and signed by E6 includes the following: "On Saturday morning we were down on North hall getting people up when I hear the nurse E8 ask for help when I enter R1's room he was hitting at E8 as she was trying to get his accu-check I came into the room and asked him to let her get his accu-check and he started hitting and kicking at me that's when E7 came into the room at the foot of the bed R1 tried to kick at him and he put his hand on R1's leg so he wouldn't kick him E8 asked him to hold still so she could get the blood, but he wouldn't he just kept on hitting at her and kicking. I have never seen E8 be abusive to any resident in this facility." A surveyor interview with E6 on 6/24/09 at 9:50am found E6 has been employed at the facility for 14 years and works on the night shift as a CNA. E6 reported she had been called into the room with R1 and E8 on the morning of 6/6/09 while on the hall getting people up. E6 indicated that R1 was being combative during a finger stick. The nurse was trying to get the drop of blood from R1's finger and R1 was very agitated and yelling "I'm going to kill you" etc. E6 put her hand on R1's leg to help E8, then E7 came in and caught R1's leg while he was kicking	F9999		

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F9999	Continued From page 46 at E8. E6 stated at times R1 is combative with care. E6 was questioned about reporting the event and E6 said she only spoke to E1 (Administrator) about the event when the statements were made. E6 did not report the events to any other staff member. E7 statement and interview: The undated written statement prepared and signed by E7 includes the following: "I E7 was doing bed check when E6 and E8 were yelling for help when I walked into the room R1 was hitting E6 and E8. so i held down R1's leg so he could not hit them. I did not know what was going on. P.S. I never have seen E8 yell or hit a resident." A surveyor interview with E7 on 6/24/09 at 1:15pm found E7 has been employed for one year and just moved from the nights to evening shift on 6/20/09 as a CNA. When questioned about the morning of 6/6/09, E7 reported he was working on the North hall early approximately 3:30am and heard a call for help. E7 entered R1's room where E8 and E6 were with R1. E7 pulled the curtain around the bed and held down R1's foot so R1 would not kick the other CNA or bed. R1 was calling out "I'm going to kill you -- get that sharp thing away" When asked about the events E7 stated "I thought she was in the wrong -- I wouldn't have held his foot if I knew the situation I walked into. E7 said the event lasted for 2 to 3 minutes and when the nurse left the room the resident was calmer. When asked about discussing the event, E7 said he did not discuss the incident with anyone. E7 said he was asked to make a statement about the events by E1. When questioned about E8's behavior with other residents, E7 indicated that he has heard E8 yell and curse at other residents on the	F9999		

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F9999	Continued From page 47 midnight shift. The surveyor questioned this because it did not match the written statement above. The written statement was handed to E7 for review. E7 was insistent that the P.S. at the bottom of the statement was not written by him. E7 stated, "I did not write that --- I would have told the truth." E7 said no one had asked him about E8's behavior other than the incident of 6/6/09. When E7 was asked for an example of E8's behavior, E7 stated on the last night working midnights E8 yelled at R4 "to shut the F--- up." E7 said he was sure R4 could verify that and other things that E8 had yelled and swore at her. E1 was brought into the interview with E7's permission and the allegations against E8 were reviewed. E1 asked E7 why he failed to report the events and E7 said he was afraid of reprisal. At this point E1 indicated an investigation into the allegations of verbal abuse made by E7 would begin immediately. 3. Interview with R4 and R5 who are roommates on 6/24/09 at 2:15pm found the two residents resting in bed. R4 was questioned if the conversation could take place with R5 present and R4 indicated she and R5 have vowed to stay together to help each other. R4 was questioned about how she was treated at the facility and she did not immediately have any negative responses. However, when questioned about how the night nurse treats her and asked about tone of voice and language, R4 responded differently. R4 was asked if E8 ever used curse words. R4 responded there is a nurse and gave examples as "move your a--" and "stop being a baby" when R4 was asking for pain medication. R4 was questioned about the use of the "F" word and R4 confirmed the nurse had used the word	F9999		

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	145664	A. BUILDING _____ B. WING _____	C 07/01/2009

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F9999	Continued From page 48 directed at her. R4 then asked R5 for help identifying the nurse and R5 identified E8 as the offender. R4 prompted R5 to help her indicating the surveyor was there to help them. R4 and R5 were asked if they had told anyone about E8's behaviors and R4 responded that she did not want to have any problems. However, when asked about who might know about the way E8 spoke with them, the response was everyone knows. When asked how the way E8 speaks with them makes them feel R4, stated it "hurts her feelings" when spoken to like that. 4. Admission/Discharge records and History indicate R3 is an 83 year old resident admitted to the facility on 8/4/09 with multiple diagnoses including: End-stage renal disease on hemodialysis, Coronary artery disease, Diabetes and Cerebrovascular accident. A Resident Assessment was completed on 6/12/09 at 6:45pm indicating skin conditions noted upon R3's return from the hospital. The form notes a 3cm bruise to the right side of the neck. The Quality Care Reporting Form indicates the date of occurrance of 6/12/09 at 3:00pm. The form indicates the location and size of the bruising only. This form indicates the event is documented in nurses notes. A review of the nurses notes for this time frame found no report of the bruising or notifications. The Investigative Report For Skin Tears/Bruises finds in the comment section that the resident returned from the hospital with the bruise after a one day stay. There is no formal statement from the resident. There is no follow-up with staff that cared for R3 prior to the hospital stay or with the persons who last bathed R3 to determine the origin of the bruise. No documentation was included to determine if the bruise was in place prior to the	F9999		

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F9999	Continued From page 49 hospital stay. 5. During the daily status meeting on 6/24/08, E1 and E2 confirmed that the abuse investigation was proceeding for the verbal abuse allegations against E8. E8 was removed from the schedule until the investigation could be completed and that inservices for all other staff had begun on Abuse Prohibition on 6/25/09 from 1:30 to 2:00pm. E8 continued to work from after the 3-day suspension on 6/13/09 until the second investigation beginning on 6/24/09. During this time on 6/20/09 the allegations of verbal abuse were committed. 6. The facility failed to follow "The Abuse Prevention Program Facility Policy" regarding: a. "Internal Reporting Requirements and Identification of Allegations" "Employees are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor or the administrator." "Supervisors shall immediately inform the administrator or designee of all reports of potential/alleged mistreatment. Upon learning of the report, the administrator or designee shall initiate an investigation." The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee." E6 and E7 (CNA's) failed to immediately report an incident with E1 (Administrator) for the	F9999		

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F9999	Continued From page 50 morning of 6/6/09. The interviews to follow find neither E6 nor E7 reported an abusive event. A surveyor interview with E6 on 6/24/09 at 9:50am found E6 has been employed at the facility for 14 years and works on the night shift as a CNA. E6 reported she had been called into the room with R1 and E8 on the morning of 6/6/09 while on the hall getting people up. E6 indicated that R1 was being combative during a finger stick. The nurse was trying to get the drop of blood from R1's finger and R1 was very agitated and yelling, "I'm going to kill you" etc. E6 put her hand on R1's leg to help E8, then E7 came in and caught R1's leg while he was kicking at E8. E6 stated at times R1 is combative with care. E6 was questioned about reporting the event and E6 said she only spoke to E1 (Administrator) about the event when the statements were made. E6 did not report the events to any other staff member or administration at the time of the incident. A surveyor interview with E7 on 6/24/09 at 1:15pm found E7 has been employed for one year and just moved from the nights to evening shift on 6/20/09 as a CNA. When questioned about the morning of 6/6/09, E7 reported he was working on the North hall early approximately 3:30am and heard a call for help. E7 entered R1's room where E8 and E6 were with R1. E7 pulled the curtain around the bed and held down R1's foot so R1 would not kick the other CNA or bed. R1 was calling out "I'm going to kill you -- get that sharp thing away." When asked about the events E7 stated, "I thought she was in the wrong -- I wouldn't have held his foot if I knew the situation I walked into. E7 said the event lasted for 2 to 3 minutes and when the nurse left the	F9999		

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F9999	Continued From page 51 room the resident was calmer. When asked about discussing the event, E7 said he did not discuss the incident with anyone. E7 said he was only asked to make a statement about the events by E1. Further, E7 was aware of potential verbal abuse against R4 from 6/20/09 and failed to report the incidents as required. The above interview contained information about further unreported verbal abuse as follows: When questioned about E8's behavior with other residents E7 indicated that he has heard E8 yell and curse at other residents on the midnight shift. The surveyor questioned this because it did not match the written statement E7 had previously given to E1. The written statement was handed to E7 for review. E7 was insistent that the P.S. at the bottom of the statement was not written by him. E7 stated, "I did not write that --- I would have told the truth." E7 said no one had asked him about E8's behavior other than the incident of 6/6/09. When E7 was asked for an example of E8's behavior, E7 stated on the last night working midnights (6/20/09 per facility time sheets) E8 yelled at R4 "to shut the F--- up. E7 said I'm sure R4 could verify that and other things that E8 had yelled and swore at her. E1 was brought into the interview with E7's permission and the allegations against E8 were reviewed. E1 asked E7 why he failed to report the events and E7 said he was afraid of reprisal. During the investigation of the events of incident of the morning of 6/6/09 with R1 the following nurses notes were located in R1's and R2's nurses notes:	F9999		

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F9999	Continued From page 52 R2's nurses notes from 6/6/08 at 8:00am ---the nurse charts "Awake, lying in bed A- O x3 c/o tx by noc staff. Report to Administrator, DON...." R1's nurses notes from 6/6/09 at 7:30am -- the nurse charts "Awake, alert, confused at times. c/o tx of noc shift. Int Adm and DON aware...." Interview with E3 (RN) on 6/23/09 confirmed that she had written the above nurses notes and she confirmed that she had spoken with the Administrator and DON on the morning of 6/6/09. Interview with E5 (Business Office Manager - weekend Administrator) on 6/24/09 at 9:35am found she had been in the facility on the morning of 6/6/09 and was made aware of the situation with R1 and E8. E5 indicated she had not called the Administrator or DON personally but talked with E3 and she indicated she had already notified them. Interviews with E1 and E2 on 6/23/09 at 2:45pm and 3:05pm respectively indicate they were not informed of the events of the morning of 6/6/09 until the Monday morning of 6/8/09 upon coming into the facility. b. V. Protection of Residents "The facility will take the following steps to prevent mistreatment while the investigation is underway. Bullet point 3 "Employees of this facility who have been accused of mistreatment will be immediately removed from resident contact until the results of the investigation have been reviewed b the administrator or designee...." Due to E7's failure to immediately report the allegation of verbal abuse against R4 from	F9999		

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F9999	Continued From page 53 6/20/09, E8 was allowed to continue working scheduled days from the 13th of June until the occasion of the second abuse allegation being made by staff on 6/24/09. c. II. Orientation and Training of Employees bullet point 5 "How to recognize and deal with burnout, frustration, and stress that may lead to inappropriate responses or abusive reactions to residents." A surveyor interview was conducted by phone with E8 (LPN) on 6/24/09 at 11:40am. E8 indicated she has been employed as an LPN with the facility for 2 years and works the night shift. E8 indicated she believed she had attended abuse training in the past year. E8 indicated in the interview that she had spoken to E1 the Sunday before (May 31) about asking for some time off so she could relax. E8 stated to the surveyor, "midnights hard, builds up on you -- stressed out." E8 related during the interview that she received a three-day suspension over the incident. E8 was called Monday and was suspended on Wednesday, Thursday and Friday. E8 stated the time off was a blessing. Interview with E1 (Administrator) on 6/30/09 during the daily status meeting found E8 had never requested time off. (A)	F9999		