STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145445	A. BUILDING _____ B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL	623 HAMACHER STREET WATERLOO, IL 62298

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F 315	Continued From page 22 removed her soiled gloves. E8 failed to offer R13 fluids after providing care. R13's Care Plan, dated 6/03/10, documents R13 has a history of a urinary tract infection with Vancomycin Resistant Enterococcus bacteria. The Care Plan lists an approach as, " Keep the tubing and urine bag below the bladder at all times", and "Encourage fluids as tolerated." The complete blood count dated 9/08/10, documents a White Blood Cell count of 12.9, (normal=5.4-9.9), indicative of infection. A Urinalysis with a Culture and Sensitivity test and a urologist consult was ordered by the physician on 9/08/10, to rule out a urinary tract infection or other issues with R13's bladder. The facility's policy and procedures entitled 'Catheter Care' and 'Catheter Maintenance', reads, "A person with a catheter will receive the appropriate care and services to prevent infections to the extent possible." E2, Director of Nursing, confirmed on 9/09/10, at 10:30 AM, that E7 knows not to place the catheter drainage bag and tubing on the floor.	F 315		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or	F9999		

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F9999	Continued From page 23 the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to protect one (R1) of 24 sampled residents from mental abuse. Facility staff failed to follow the abuse policy, to appropriately intervene, to immediately report to administrator and the Department, and to timely investigate an allegation of abuse to prevent further abuse from occurring for one (R1) of 24 sampled residents who was subjected to mental abuse. Findings include: The facility's final report, dated 6/2/10, regarding the allegation E9 (Certified Nurse's Assistant/CNA) mentally abused R1, was	F9999		

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F9999	Continued From page 24 reviewed. The report documented the following: E10 (Licensed Practical Nurse/LPN) reported an allegation of verbal and physical abuse to E11, LPN/Nursing Coordinator. E10 reported E13 (CNA) came to her and noted E12 (CNA) had witnessed E9 poking, tickling, jumping towards residents saying "boo," frequently antagonizing R1 in the dining room causing R1 to yell, throw food or drinks and becoming very upset in the dining room. The documented interview with E12 (CNA), dated 5/27/10, noted "E12 was asked to provide information about an incident with resident R1. She (E12) stated on her 2nd day of orientation on Cottonwood with (E14, CNA), R1 was incontinent and already 'irritated.' She stated they need to change her due to incontinence and her, E14 and E9 were in the room. E12 stated E9 made it worse, she rolled up a towel and slapped at R1's face. When asked if anyone else saw this she stated E14 saw it and made a comment 'she forget about it in two minutes.'" The statement continued "E12 stated that R1 had increased agitation when on the toilet and this is when (E9) did this with the towel. She (E12) stated (E9) would go real fast at her (R1). (R1) became so irritated that we couldn't put pants on her, they had depends on her. She also stated that (R9) pointed to (R1's) picture of her husband and said 'I fu---- your husband' and did the 'blow job' motion. She stated (E9) and (E14) were laughing. When walking out of the room (E9) made the peace sign and said 'peace nigga.'" This incident occurred on 5/21/10. E13 wrote a statement on 5/27/10 and documented the following: "Every time I work	F9999		

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F9999	Continued From page 25	F9999		

Arbor Court and (E9) works, she's constantly aggravating and picking on (R1). I've seen her lots of times doing this in the dining room. She walks by her getting in her face, poking her, making fun of her. (R1) gets made and then starts cussing. (E9) will keep on and then (R1) gets even more made and eventually starts throwing food, trying to hit (E9). Then she (R1) has to be taken out of the dining room. I've told (E9) to stop multiple times. She (E9) just gives me dirty looks. Then when I was orientating (E12) she told me a terrible thing. She told me she saw (E9) flip (R1) with a hand towel in the face multiple times. (E14) heard (E9) tell (R1) 'I fu---- your husband' as (E9) was laughing and pointing to a picture of (R1) and her husband. This is resident abuse! I told (E12) to let someone know. She (E12) said she's new and doesn't want people to not like her and be mean to her. So today (5-27-10) I told a nurse that I could trust to do the right thing, (E10).

The documented interview with E14, dated 5/27/10, noted "After interviewing several staff we interviewed (E14) a second time about the above information and (E14) stated and giggled 'oh yeah I do remember her doing the sign of the blow job' but E14 could not remember if anything was said or what made (E9) do this. (E14) admitted she did laugh and did not report this to the nurse and knows it was wrong. (E14) denies seeing (E9) snap the towel in the residents face or say I f----- your husband."

E14 wrote a statement on 5/27/10 and documented the following: "During dinner time is usually when (R1) gets very angry. At times (E9) will poke her and say boo to try and scare her. Sometimes she will keep doing it just to make her

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angry. This is during supper time so anybody that states they never see it is not telling the truth because everyone usually sees it. There are times when (E9) is very sweet to her. Of course I don't like anyone getting into trouble but we are here to care for people not make it possible for them to harm themselves."

E17 (CNA) wrote a statement on 5/27/10, and documented the following: "On many occasions I have seen (E9) antagonize (R1) in the dining room such as tickling her, poking her, laughing at her. (R1) can be in a wonderful mood and (E9) will walk up and tickle, et her and keep doing it until she gets made. (R1) will become combative and (E9) thinks it hilarious. She then leave (E16) who is pregnant to deal with (R1) and care for her. Because of (E9), (R1) has hit several staff member and isn't herself."

E16 (CNA) wrote a statement, not dated, and documented the following: "I was asked to write down some things that have been going on with my resident, (R1). For the last couple of months I have noticed that there have been some behaviors going on with her. It seems that after I take her to supper she gets very upset in the dining room with the workers and sometimes with other residents that are being loud. I don't get to feed so I usually check on (R1) when I'm not real busy. Sometimes I Noticed that a CNA sometimes picks on her and then gets her all upset where she is wanting to throw or spill her drinks on them or other residents. (R1) also can become combative with whoever takes her out of the room. I don't think this is fair to her, she shouldn't have to go to supper and be picked on. She is diabetic and needs to be able to eat in a nice quiet environment. And then if she is taken

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F9999	Continued From page 27 out of the dining room then she is upset wanting to hit or slap me when I get her back to her room." An interview with E15 (CNA) was conducted on 5/28/10 and noted "(E15) was asked if she was aware of any problems with (R1) in the dining room. She stated when (E9) sits at the table she noticed that (R1) wouldn't eat. If (R1) started in with behaviors (E9) would be 'short and snippy' with her. She said (E9) would laugh at (R1's) behaviors and others also laughed." An interview with E18 (CNA) was conducted by the facility on 5/28/10 and noted "He sated that (E9) 'teases' (R1). He said (E9) would say stuff to (R1) all the time. He also stated (E9) would do it to 'antagonize' (R1)." On 9/7/10, at 4:00 PM, E1 (Administrator) and E2 (Director of Nurse's) were interviewed regarding this allegation. Both noted all of the staff interviewed confirmed the allegation with the exception of E9. E2 indicated the Illinois State Police was called to assist with interviewing the staff due to the seriousness of the allegation. E2 and E1 confirmed none of the staff ever reported E9's behavior towards R1 until E13 reported the allegation to E10. R1's physician's order sheet, dated 9/10, indicated she had a partial diagnosis of Dementia with Anxiety. R1's Minimum Data Set, dated 8/13/10, indicated she had short and long-term memory problems. On 9/7/10, R1 was questioned regarding the incident and could not answer any of the questions due to her cognitive impairment.	F9999		

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F9999	Continued From page 28 The facility's abuse policy, not dated, indicated "Any long-term care facility Administrator, employee or agent who becomes aware of an allegation of mistreatment, neglect, abuse or misappropriate of a resident's property shall report the allegation immediately." The policy also noted under the Section of Prevention "3. Staff are encouraged and expected to intervene and correct any situation that may predispose abuse, etc. 4. Staff is encouraged to be proactive before situations get out of control. 5. Staff will be supervised to identify inappropriate behaviors such as using derogatory language, rough handling, and ignoring residents while giving care. If this identified staff will inform their supervisor/administration immediately." (A)	F9999		