STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146133	A. BUILDING _____ B. WING _____	C 12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHABILITATION & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

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F 493	Continued From page 36 Staff were eduction on the reporting policy and procedure.	F 493		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) Section 300.610a) a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 37 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to identify potential abuse. The facility failed to implement their Abuse Policy and Procedure by not immediately protecting residents, conducting an investigation, reporting the allegation to the state governing agency, and notifying resident families of a staff member	F9999		

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mentally abusing and neglecting residents.

This has the potential to affect all 48 residents residing in the facility.

The findings include:

The Facility Data Sheet, filled out by E1 (Administrator) presented on 11/23/2011 at 9:30 AM, shows the facility has 48 residents currently residing in the facility.

On 11/23/2011 at 9:00 AM, Z1 said a telephone memory card (SD)was found outside of the facility. Z1 said the SD card belonged to E15 (Certified Nursing Assistant - CNA). Z1 said the card was viewed on his cellular phone. Videos of R1,2, & R3 were seen. Z1 said the video showed R3 "about ready to fall off the bed". Z1 said the only thing keeping R3 from falling on the floor, face and head first, were the blankets. Z1 said there is audio and video of R3's roommate, R4, asking if R3 is all right. Z1 said the entire time R3 was hanging off the bed, E15 was saying 'good morning (R3), good morning beautiful'. Z1 said the card also had video of R1 & R2. Z1 said the video showed R1 and R2 being woke up early in the morning. Z1 said, "I was floored when I saw what went on!" Z1 said there was video of R2 in bed, being woke up at 4:00 AM. He didn't want to get up, he held the sheet over his head. Z1 said there was also video of R2's roommate, R1, sitting up in his wheel chair, sleeping, with his tee shirt just over his head, and around his neck. Z1 said E15 shook the resident's face and tapped both sides of his face, trying to get the resident to open his eyes. Z1 said another video was taken at 4:30 AM, showing both R1 & R2 sitting up in

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their wheel chairs, next to each other, asleep. Z1 said he showed the video, from his cell phone, to E8 (housekeeping supervisor), E2 (Director of Nursing), and E1 (Administrator). Z1 said, "When E1 saw the video she said nothing except asked who the CNA was. (E1) took the SD card.

On 11/23/2011 at 1:25 PM, E1 said she is the facility Abuse Coordinator. E1 said she was aware of video that had been taken of R3. She said the SD card had been found outside of the facility by E3 (Maintenance). E1 said she viewed the SD card on E3's cellular phone. E1 said she heard a female voice talking on the video. E1 said she saw video of R3 laying on the side of the bed. E1 said, "I don't remember her off of the bed, but at the edge of the bed. I was disturbed. The person taking the videos did not have permission to take the pictures. I haven't talked to E15 because I don't have proof it belongs to her. I didn't want to make a big deal of it." E1 said Z3 (Corporate Nurse) has the SD card. E1 said she did not do an investigation of the incident and did not notify the state agency, the resident's physicians, or their families. E1 said she did not interview any residents or staff who may have been witness to the incidents. E1 said she did not interview E15 because she no longer works at the facility. E1 said, "I didn't even think about why the SD card was out of the cellular phone it was in, or that there might be pictures of other residents on the SD card. I did not notify the registry of R15's termination of employment with the facility. I had heard she was working at an assisted living facility."

On 11/23/2011 at 3:30 PM, Z3 (Corporate Registered Nurse) brought the SD card to the

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facility. She said she had had the card for approximately 1 week. She said she did not have a way to view the SD card.

On 11/23/2011 at 3:45 PM, the SD card was viewed with Z3 (Corporate Registered Nurse) and E1 present. While viewing various pictures on the SD card, E1 verified pictures of E15 and her sister on the SD card. E1 concluded the SD card belonged to E15. A video time stamped 8/28/2011 was viewed. The length of the video is 41 seconds. R3 was observed with her sheet and blanket tucked under the mattress. The resident's body is completely off of the bed. Another video time stamped 9/18/2011 was observed. R1 & R2 were video taped at 4:30 AM while E15 (Certified Nursing Assistant) was trying to wake them up by pulling bed linens off R2's head, and video of his exposed legs. E15 took close up frames of R1 & R2 sleeping in their wheel chairs and video of E15 pulling R1's nose, shaking his chin, and tapping him on the sides of his face.

On 11/23/2011, after viewing the videos, E1 said she had not seen all of the videos. E1 said, "I had no way to view the SD card. If I had seen all of those videos I would have done an investigation.

The facility's Abuse Prevention Program (11/11/11) states: "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its resident, and has attempted to establish a resident sensitive and resident secure

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environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of mistreatment, neglect or abuse of our residents. This will be done by:
"...Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, neglect, and abuse of resident and misappropriation of resident property;
Immediately protecting residents involved in identified reports of possible abuse;
Implementing systems to investigate all reports and allegations of mistreatment, neglect, abuse of residents and misappropriation of resident property; promptly and aggressively, and making the necessary changes to prevent future occurrences; and
Filing accurate and timely investigative reports...
Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, neglect, and abuse of resident and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation."

The Resident Protection Investigation Procedure (s) state, "...After reviewing the final report, the administrator or designee is responsible for forwarding an approved copy of the final report to the Department of Public Health within five working days of the occurrence. The administrator or designee will also notify the resident's representative of the results of the investigation..."

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