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F 223	Continued From page 6 The facility will take steps to prevent mistreatment while the investigation is underway: -Accused individuals not employed by the facility will be denied unsupervised access to the residents during the course of the investigation. -Employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible abuse, neglect or misappropriation of property shall not complete the shift as a direct care provider to the residents. In addressing Internal Investigation of Abuse the policy notes: -All incidents will be documented, whether or not abuse occurred, was alleged or suspected. -any incident or allegation involving potential/actual abuse, neglect or misappropriation will result in an abuse investigation.	F 223		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	F9999		

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F9999	Continued From page 7 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,	F9999		

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seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on record review, interview and observation the facility failed to

Prevent the development of three areas of avoidable pressure ulcers to R 16 & R 9.
Re-evaluate treatment modalities that have not been effective in preventing recurring pressure sores for their effectiveness and develop and implement individualized interventions based on the identified needs of R16 and 9.
Prevent worsening of R 9's pressure ulcer.

These failures resulted in R16 and R9 acquiring multiple avoidable pressure ulcers and the worsening of the acquired pressure ulcer on R9's coccyx which had developed into an unstageable; recurrent pressure ulcers to R16's ankle due to orthotic cast and then becoming infected with MRSA. This is for two residents identified with

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pressure ulcers in the sample of 30.

Findings include:

Review of admitting face sheet shows R16 is 81 years old and has been a resident at this facility for almost 14 years. Care plan dated 2/22/10 and 11/4/11 shows R16 wears a padded ankle foot orthotic (AFO) clamshell brace to her right lower extremity. R16 has a history of pressure ulcers, blisters and petechial areas developing under this brace on the lower extremity. This care plan also states the "clamshell brace is to be on 23 hours a day, circulation is to be checked every shift and the charge nurse is to take the clamshell off every morning for one hour, wash and dry leg and foot. Apply nystatin powder and a clean dry cotton stockinette is to be placed under brace." Review of pressure sore documentation shows R16 redeveloped a pressure sore to the right outer aspect of ankle on 8/30/11. It was found at a stage III measuring .6 x 1 cm. By 10/4/11 it was a dark necrotic area and by 12/9/11 it contained 80% slough. R16 found to have facility acquired MRSA in this wound on 12/23/11.
E4 (assistant dir of nursing) stated on 2/16/11 at 10:00am that R16 has been on antibiotics for the MRSA in this wound since then. The care plan interventions/approaches noted above have not been evaluated for their effectiveness nor have they been revised since R16 redeveloped this pressure ulcer.

A progress note by the orthotic company who supplies and adjusts R16's AFO (clamshell) dated 7/14/11 states that R16 "appears to have a lot of edema and is not controlled this am with use of either AFO or compression garment (not on

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patient). " Podiatry progress note dated 9/19/11 states left ankle ulcer from brace pressure.

Interview and observation on 2/16/12 at 10:30am along with E20 (wound nurse) found R16 alert and oriented, sitting in her wheelchair in her room. R16 is unable to verbalize due to prior stroke but is capable of answering yes and no. R16 had the right leg slightly elevated on a footrest and the AFO was applied. E20 removed the AFO and the elastic stocking. The lower extremity, including the entire foot and toes, was very edematous with 3+ pitting edema. The pressure area was observed to have a very thin layer of bluish-red tissue. Also noted was a quarter size reddened area on the inner aspect of the right heel that had what appeared to petechiae. There was slight spotting apparent on the padding inside the clamshell. There was no documentation regarding this area in the medical record.

2. Review of face sheet shows R9 is 90 years old, admitted to facility on 8/4/07. Care plan dated 8/13/10 and 12/21/11 states R9 requires assist in turning and postioning in bed and transferring out of bed. Review of pressure sore documentation dated 12/12/11 shows a stage II was found on the coccyx measuring 2.8 x 5 x .1 cm with serosanguineous drainage. One week later it had declined to an Unstageable wound with 85% slough and measuring 3.5 x 3.0 cm with a bridge.

E23 (nurse's aide) stated on 2/16/12 at 1:20pm that R9 does like to be in bed and use to sit up in her wheelchair all day. This was repeated by E24 (wound nurse) on 2/16/12 at 2:00pm who also stated R9 developed a heel wound that recently

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F9999	Continued From page 11 closed and also the current pressure ulcer to the coccyx. During this observation of R9's pressure sore to the coccyx, it was observed to be healing with small areas of slough and a bridge of healthy tissue running in the center. E3 (director of nursing) stated on 2/17/12 at 10:10 am the facility has not followed its own policy and procedure and has not had labs drawn to assist in analyzing if dietary issues were also a cause of this ulcer. (B) LICENSURE VIOLATIONS 300.690a) 300.690b) 300.690c) 300.1210b) 300.3240a) 300.3240b) 300.3240e)	F9999		

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Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

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F9999	Continued From page 13 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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) 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, record review, and interview the facility failed to protect residents from verbal, physical and mental abuse. This is for is for five residents in the sample of 30 (R1, R15, R19, R20, and R21) and two residents outside of the supplemental sample (R31 and R32).	F9999		

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The findings include:

1. On 2/15/12 at 10:15 a.m. during an interview with E6 regarding R15, E6 alleged Z1 (Hospice CNA) had physically abused R15. E6 stated Z1 had brushed R15's teeth. E6 stated Z1 came and told her, "I shoved the toothbrush in R15's mouth and knocked her tooth out." E6 stated when Z1 told her this she went to R15 and checked her teeth. E6 stated upon observation of R15's teeth, R15 had a bottom tooth missing. E6 stated the incident happened approximately one month ago and she reported the incident to Z2, E11 and E8 when Z1 reported the incident to her . E6 also stated Z1 was "rough" with patients at the facility.

Observation of R15's teeth on 2/15/12 at 10:30 a.m. with E6 noted R15 to
have two missing bottom teeth which were the teeth to the left of her bottom middle teeth. At this time E6 stated, "Now she has two teeth missing. She only had one missing when I checked her."

Review of a dental progress note for R15 dated 7/19/11 showed R15 had multiple broken upper teeth but with "multiple intact lower teeth."

Interview with Z2 on 2/16/12 at 12:15 p.m. noted Z2 to say,

"I heard E6 and another CNA talking about how Z1 had told E6 about how she shoved the toothbrush in R15's mouth and knocked R15's tooth out. This was on 1/10/12. There was a lot of complaints about Z1. The first complaint was about R15, then a complaint about her being rough with R32 with his bath, then issues with

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R19 and her scolding him.

Z2 went on to say, "On 1/26/12 I asked E4 and E5 (Assistant Directors of Nurses) if any staff had reported anything to them about R15. I told them about this issue with R15's tooth being knocked out on that date."

Interviews with E4 and E5 on 2/16/12 at approximately 2:00 p.m. noted both to say they knew approximately two weeks ago at least six facility staff members had reported Z1 to the Hospice Supervisor complaining of resident care issues with Z1. During these interviews E3 (Director of Nurses) stated, "We didn't think this warranted an investigation."

2. During interview with E7 (CNA) on 2/15/12 at 10:25 a.m. regarding Z1 (Hospice CNA) E7 stated, "I heard people say she was scrubbing the residents real hard during their baths. She treats people rough. She scolded R20 (R19's room mate). He came and told me she did. I witnessed her scolding R19. He's on Hospice. I reported it to Z2 (Hospice Nurse) and the Hospice Social Worker. I reported it to our nurse too. These incidents happened when Z1 first started working here. (12/2011)."

3. During interview with E9 (CNA) on 2/16/12 at 10:05 a.m. E9 stated, "R21 expired on 1/21/12. She was on Hospice. She used to make a funny sound and Z1 would tell her, "Shut up, shut up. Do you think that's funny? Stop making that noise. Z1 would talk to R21 in a smart alecky way. I also heard Z1 was filing R31's nails real hard during nail care. I called the Hospice

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company and reported her. This happened in Dec. 2011 or Jan. 2012."

4. During interview with E10 (LPN) on 2/16/12 at 10:15 a.m. regarding Z1, E10 stated, "One time Z1 was giving R21 a bath and I heard R21 crying. Z1 had R21 in a chair and was filing her nails really hard. I told her to "stop you're too rough" and she kept doing it. I had an argument with her about it. I reported her to Z2 (Hospice Nurse) and I mentioned it to E8 (RN Supervisor). One time I also had to make Z1 give R31 a hot meal. She was going to give R31 a peanut butter and jelly sandwich instead of giving her a hot meal!"

5. During interview with E8 (RN Supervisor) on 2/16/12 at 11:55 a.m. E8 stated she had witnessed Z1 pushing R31 so fast in her wheel chair she almost ran R31 into the wall. E8 stated Z1 is "very rough and reckless with residents."

Further interview with E8 noted E8 to say none of the abuse issues with Z1 had been investigated or reported to the Illinois Dept. of Public Health. E8 stated no one had informed her of the above abuse issues until 2/9/12.

Interview with E2 (Assistant Administrator) on 2/15/12 at 1:15 p.m. noted E2 to say Z1 (Hospice CNA) started working at the facility on 12/9/11 and worked at the facility until 2/10/12 when she was finally asked to leave the facility after the abuse of R32 was reported to E8. Continued interview with E2 disclosed the facility did not ensure a background check, registry check, or reference checks had been done by the Hospice company before Z1 started working at the facility.

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On 2/15/12 Z1's background check, registry check, and reference checks were requested from the Hospice company. Z1's registry check was not done until 12/23/11. Z1 started working at the facility on 12/9/11. The registry check was not done until two weeks after Z1 started working at the facility. Z1's references showed she had worked at another Hospice company from 11/2006 to 8/2011. Z1 notes the reason for her leaving the other Hospice company was, "The Hospice company didn't support me after accusation by nursing home CNA."

Z1 continued to work at the facility from 12/9/11 to 2/10/12 even though accusations of abuse were reported by the facility CNA's and nurses in Dec. 2011, Jan. 2012, and Feb 2012 to the administrative nursing staff and the Hospice company.

Review of nurses notes, facility incident reports, and facility abuse investigations showed no nursing documentation, no incident reports, and no abuse investigations were done regarding alleged abuse of R15, R19, R20, R21, or R31. An abuse investigation was not started on R32 until 2/10/12.

6. On 2/14/12 at 10:45 am, R1 stated yesterday evening (2/13/12), two girls helped her get ready for bed. R1 stated, "Those girls threw me into bed. I am 93 years old and it hurts when they throw me like that. I don't know what I said or did to get them so mad. The tall one (E13) is rough even when she's trying to be nice. When they left my call cord was down behind my bed. I called and called but no one came because the girls had shut the door. They had put my diaper on wrong

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and I wasn't going to sleep with it like that. Finally the nurse (E26) came in and I told her what happened. I was so scared if the place caught on fire I wouldn't be able to call for help because there was no call light and no one could hear me because the door was shut. After I talked to (E26) she made them come back and fix my diaper then the girls came in and tried to smooth things over but I didn't talk to them. They were not too happy."

E2 (asst. administrator) stated on 2/15/12 at 2:45pm the facility had begun an investigation into this allegation of abuse but not until 2/15/12 when another staff person overheard surveyor speaking with R1 about the incident. E2 confirmed that E26, (the nurse whom R1 reported the allegation of abuse to shortly after it occurred on 2/13/12 about 8:00pm), failed to immediately follow the abuse protocol, remove the two nurse's aides from working, report the allegation to the appropriate personnel, and begin an investigation.

Review of the facility's policy on Resident Abuse, Neglect, and Mistreatment addressing Internal Reporting Requirements denotes:

-Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about, or suspect to the administrator immediately. Employees are also expected to notify supervisory staff.
-An investigation will be immediately initiated.
-The nursing staff is additionally responsible for reporting on a facility incident report the

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appearance of suspicious bruises, lacerations, or other abnormalities 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 their designee.

In addressing Protection of Residents the policy notes:

The facility will take steps to prevent mistreatment while the investigation is underway:

-Accused individuals not employed by the facility will be denied unsupervised access to the residents during the course of the investigation.
-Employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee.
Employees accused of possible abuse, neglect or misappropriation of property shall not complete the shift as a direct care provider to the residents.

In addressing Internal Investigation of Abuse the policy notes:

-All incidents will be documented, whether or not abuse occurred, was alleged or suspected.
-any incident or allegation involving potential/actual abuse, neglect or misappropriation will result in an abuse investigation.

(B)