STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146016	A. BUILDING _____ B. WING _____	09/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET REHABILITATION & HEALTH CARE	129 SOUTH 1ST AVENUE CANTON, IL 61520

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F 467	Continued From page 24 E12, Maintenance Director stated on 09/19/2012 at 01:45 PM "We don't have the fans on a cleaning schedule. No staff has reported the exhaust fans not working to me.	F 467		
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 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. 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) Based on interview and record review, the facility	F9999		

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failed to immediately report allegations of abuse to the Administrator, failed to conduct thorough investigations into alleged abuse, and failed to immediately remove the alleged perpetrator to prevent further abuse for two of four residents (R2,R16) reviewed for abuse in the sample of 21. This failure resulted in a second incident of abuse by the same staff member.

The facility also failed to operationalize their Abuse Prevention Program Facility Policy by failing to restrict employee E6 (Certified Nursing Aide), alleged to have committed resident abuse to two residents (R2,R16), from having direct contact with residents after the alleged abuse occurred. The facility failed to immediately notify the Administrator of the alleged abuse and failed to notify the Physician or Family in a timely manner after the alleged abuse.

These requirements are NOT MET as evidencied by:

Finding include:

1. The IDPH (Illinois Department of Public Health) notification report dated 4-20-12, signed by E1 (Administrator/Abuse Coordinator) documents that at 9:00p.m. on 4-19-12, E6 (Certified Nursing Aide) was yelling at R16 "stop being mean." Shortly after, E6 was holding down another resident's (R2) left arm in attempt to change her into her nightgown. The report documents that the statements were not brought to the Administrator's attention until 10:25p.m on 4-19-12 by E7 (Licensed Practical Nurse).

Upon interview on 9-18-12 at 1p.m., E1 stated

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that on 4-19-12 he was notified at 10:30p.m. by E7, Licensed Practical Nurse, of a suspected allegation of abuse against R2. E1 stated that he left it up to E7 to ensure that E6, alleged perpetrator, was sent home and that he did not interview E6 until 4-20-12 at 4p.m. E1 stated that he could not remember if he came in the night of the suspected allegation to do witness statements or initiate the abuse investigation.

E7's (Licensed Practical Nurse) untimed witness statement dated 4-19-12 documents the following information:

E7 heard E6 (Certified Nursing Aide) arguing with R16 several times and asked E6 to leave the resident's room several times. E7 told E6 "you can't argue with (R16) when he is mad." E7 stated "(E6) kept going on that the residents can't treat me like that." According to this document E6 was very upset and agitated. E7 left the hall to get supplies from another hall and when he returned to the hall he heard R2 yelling from R2's room, "you are killing me." E7 went to R2's door and opened it. E7 witnessed E6 yanking R2's gown off and slamming it to the bed. E6 leaned over the resident and held her down and E7 heard a slap. E6 then turned around and saw E7 standing in the doorway. E7 asked E6 if she slapped R2 and she said "no". E6 stated that she was holding R2 down and grabbing her wrist and it popped. E7 told E6 she couldn't do that and leave R2 alone. E7 documented that he put a catheter in another resident and then called E3 (Resident Care Coordinator). E3 instructed E7 to walk E6 out of the building and to call E1. E7 documented that E6 stated prior to leaving the building that she grabbed R2's wrist and heard a

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pop and she was holding R2 down because R2 was fighting her.

During Interview on 9-18-12 at 1:45p.m., E7 (Licensed Practical Nurse) stated E6 (Alleged Perpetrator) is "high strung and these people (the residents) get to her." E7 stated that "around suppertime, around 5:30 p.m"on 4/19/12 E6 made R16 "mad." E7 asked E6 to leave R16's room twice because E6 was arguing with R16. After asking E6 to leave R16's room twice, E7 later heard E6 and R16 arguing about a watch. E7 stated that he tried three more times to get E6 to leave the room but, E6 kept saying "no" and stated "why should I have to leave the room? (R16) is being mean to me." E7 stated that he had to make E6 leave the room. E7 states that around 6-7p.m. that same night, he heard R2 yelling and went down to R2's doorway. E7 observed E6's hand go down on R2's arm and heard a "pop" E7 stated he called E6 to R2's doorway and asked if E6 hit R2 and she stated no. R7 stated he then told E6 he thought she hit R2. R6 stated "no" to E7. E7 stated he was unsure if E6 hit R2. E7 then stated that after this occurrence he helped E6 put R2's gown on and sent E6 to go work with other residents while he put a catheter in another resident. E7 stated that after he placed the catheter he talked to his mom, who is an employee with the facility, about E6 arguing with R16 earlier that night and about E6 allegedly slapping and holding down R2. E7 stated that his mom told him he "better call and report it" to E3 (Resident Care Coordinator). E7 stated he called E3 around 7-8:30p.m. E3 instructed E7 to send E6 home. E7 stated he sent E6 home but did not explain to E6 why she was to go home. E7 stated he was unsure if

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called the Administrator about the above occurrences.

Although E7 stated that he sent E6 home, E6's time card documents that E6 worked on 4-19-12 from 2:15 p.m. to 10:00 p.m. On 9/20/12 at 10:27 a.m. E1 (Administrator) verified that an entire second shift is 2:15 p.m. until 10:00 p.m.

During interview on 9-18-12 at 3:07p.m., E3 (Resident Care Coordinator) stated she received a call around 7-8:30p.m., on 4-19-12, from E7 stating he saw E6 holding down R2's arms to put a gown on her and heard a pop. E3 stated she instructed E7 to have E6 leave the facility pending investigation. E3 stated she called E1 and Z1 (Corporate Nurse) later that night and reported the incident. E3 also stated that E7 told her that E6 was in a "bad mood" earlier that night .

E3's (Resident Care Coordinator) untimed witness statement dated 4-19-12 documents she received a call at approximately 9:30p.m. from E7(Licensed Practical Nurse) stating that E6 (Alleged Perpetrator) had a verbal disagreement with R16 and E6 had been removed from the room. E7 states that later he heard R2 yell out, so he went to the room and observed E6 holding down R2's left arm, and heard a smack. E7 stated he told E6 to leave the room. E3 instructed E7 to remove E6 from the facility immediately pending investigation. E3 documented that she called E1 later that night.

On 9-24-12 at 1p.m., E3 stated that her witness statement dated 4-19-12 was supposed to be dated 4-20-12, as she did not start taking witness statements for the investigation until 4-20-12 at

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F9999	Continued From page 29 5:30a.m. According to the witness statement signed on 4-20-12, E3 (Resident Care Coordinator) did an assessment of R2's skin and bilateral arms. E3 noted R2 to be guarding her left arm. On 4-20-12 at 12:00p.m., a Doctor order was received to do a portable Xray of the left arm and elbow. On 4-21-12 at 1a.m., the X-ray report documents that R2 had an acute fracture of the left forearm. According to E6's (Alleged Perpetrator) time card, the facility allowed E6 to continue to work with residents from around the evening mealtime, 5:30 p.m. to 10:00p.m. when E6's time card documented that she clocked out. On 9-19-12 at 2:20p.m., E2 (Director Of Nursing) states that no assessment, investigation, or internal incident report were done regarding the alleged verbal abuse on 4-19-12, for R16. 2. According to the facility Abuse Prevention Program Policy last review dated 11-1-11, all 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 by the administrator or designee. Employees accused of alleged mistreatment shall not complete their shift as a direct care provider to residents. The Policy also states that employees are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor and the Administrator. The Administrator or designee will also inform the resident or resident's representative of the report of an occurrence of	F9999		

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potential mistreatment and that an investigation is being conducted.

During Interview on 9-18-12 at 1:45p.m, E7 (Licensed Practical Nurse) verified he was aware of several verbal altercations between E6 (Certified Nursing Aide) and R16 on 4-19-12 around 5:30p.m. and a physical altercation between E6 and R2 around 6-7p.m but did not report either altercation to E3(Resident Care Coordinator) until between 7p.m to 8:30p.m. E7 verified that he did not ask E6 to leave the building until sometime after he spoke to E3. E7 was unsure if he reported the allegations to E1.

Upon interview on 9-18-12 at 1p.m., E1 stated that on 4-19-12 he was notified at 10:30p.m. by E7, Licensed Practical Nurse, of a suspected allegation of abuse against R2. E1 stated that he left it up to E7 to ensure that E6, alleged perpetrator, was sent home and that he did not interview E6 until 4-20-12 at 4p.m. E1 stated that he could not remember if he came in the night of the suspected allegation of abuse to do witness statements or initiate the investigation.

The IDPH (Illinois Department of Public Health) notification report dated 4-20-12, signed by E1 (Administrator/Abuse Coordinator) documents that verbal abuse occurred at 9:00p.m. on 4-19-12, when E6 (Certified Nursing Aide) was yelling at R16 "stop being mean". Shortly after, E6 was holding down another resident's (R2) left arm in attempt to change her into her nightgown. The report documents that the statements were not brought to the Administrator's attention until 10:25p.m on 4-19-12 by E7 (Licensed Practical Nurse).

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F9999	Continued From page 31 E3's (Resident Care Coordinator) untimed witness statement dated 4-19-12 documents the following: E3 received a call at approximately 9:30p.m. from E7(Licensed Practical Nurse) stating that E6 (Alleged Perpetrator) had a verbal disagreement with R16 and E6 had been removed from the room. E7 states that later he heard another resident (R2) yell out, so E7 went to R2's room. E7 observed E6 holding down R2's left arm, and heard a smack. E7 stated he told E6 to leave the room. E3 instructed E7 to remove E6 from the facility immediately pending investigation. E3 then documents that she called E1 (Administrator/Abuse Coordinator later that night. According to E6's (Alleged Perpetrator) time card, although E3 documented that she told E7 (Licensed Practical Nurse) to remove the alleged perpetrator, E6 continued to work with residents from around the evening mealtime, 5:30 p.m. to 10:00p.m. when E6's time card documented that she clocked out. According to the witness statement signed on 4-20-12, E3 (Resident Care Coordinator) did an assessment of R2's skin and bilateral arms. E3 noted R2 to be guarding her left arm. On 4-21-12 at 1a.m., the X-ray report documents that R2 had an acute fracture of the left forearm. On 9-19-12 at 10:45a.m., E1 provided all abuse allegations for the past year. E1 did not provide an investigation/report for 4-19-12 for R16. Upon interview on 9-19-12 at 2:25p.m., E2 (Director Of Nursing) stated that no internal	F9999		

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F9999	Continued From page 32 investigation or incident report was done and the Doctor and Family were not notified of the alleged verbal abuse that occurred on 4-19-12 to R16. The Facility Incident Report Form for R2 documents that R2's family were not notified of the alleged physical abuse that occurred on 4-19-12 until 4-21-12 at 9a.m. (A)	F9999		