STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006514	A. BUILDING: _____ B. WING _____	11/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

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S9999	Final Observations Statement of Licensure Violations: 300.3240a) 300.3240e) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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 are not met as evidenced by: Based on observation, record review, and interview the facility failed to keep a resident from being physically abusive toward a resident and failed to remove staff from direct care after an incident with (R5). This failure resulted in R11 being abused by the same staff person and R14 having the potential to be abused. This applies to 3 of 5 residents (R5, R11, R14) reviewed for abuse in the sample of 15. The findings include:	S9999		

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R5's November, 2013 Physician's Order Sheet shows that R5's diagnoses include Dementia.

R5's Minimum Data Set (MDS) assessment of 9/24/13 documents that R5 requires extensive assistance of two or more persons for transfer, and dressing. R5 was unable to complete the cognitive summary assessment.

The Occurrence Report dated 11/17/13 documents that it was reported to E1 (Administrator) that E5 (Certified Nursing Assistant) was rough with R5 when providing care. The police were notified.

On 11/19/13 at 9:30 AM, E7 (Human Resources) said that she had been the house supervisor the past Sunday (11/17). She said that Z2 (Agency Nurse) reported to her that E5 (CNA) pushed R5 against the wall striking his knees. (Rolling R5 in his bed) E7 said that she called E1 (Administrator) and E2 (Director of Nursing) and was told to send E5 (CNA) home. E7 said that while she was calling E1 and E2, E5 was in the room of R14.
R14's Minimum Data Set (MDS) assessment of 7/31/13 shows that she was unable to complete the cognitive summary test, and requires extensive assistance with activities of daily living.
E7 said that she had heard that R11's family had reported that E5 was also rough with R11.
E7 said " I don't like it, I think some of the rooms are small, and sometimes she (E5) is a little rough." E7 said that Z2 (Agency Nurse)) had asked E5 (CNA) to stop taking care of R5 and go assist R11 because the family wanted him to lay down. R11 was having trouble breathing.
E7 said she went to R11's family and told them that she had sent E5 (CNA) home. E7 said in her

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opinion E5 was physically abusive to R11. E7 said that R5 does not speak, but E19 the nurse heard R5 say "ouch" when E5 pushed him and struck his knee.

On 11/19/13 at 10:55 AM Z2 (Registered Nurse/Agency) said that she was not aware that E5 (CNA) had been approached by another nurse to go and help R11. She said that R11 was short of breath and his family was asking for help. The family asked how much longer would E5 be. I asked E5 if she could stop taking care of R5 and go help R11. She (E5) said " Is that patient more important than the one I am taking care of ?" Z2 said I asked her again if she could just stop for a minute and go help R11. E5 (CNA) pulled the dresser draw out hard and it fell on the floor. I asked E5 if that was necessary. I saw R5 come back quickly in his bed, like bouncing back from the wall. I saw E5's hands coming down. She pushed R5 hard into the wall. I checked out R5 he had a red area on his knee. I made a written report to E7 (supervisor that day).

On 11/19/13 at 10:00 AM, E6 (CNA) said she went down the 200 hall when she came into work on Sunday. (11/17) She said she started around 6:00 AM. She said that at 7:00 AM she had gone to the 100 wing to help put R11 to bed. I went to help out because I heard the family was asking to have R11 put to bed. I knocked on the door of R11's room and saw that R11 was already bed. Z1 told me the girl who put R11 to bed was very rough with him. She told me that when E5 put the stand lift up to him , and didn't give him an opportunity to hold on, she pushed him in the lift and hit the back of his legs on the bed frame. Z1 said E5 then walked out without saying a word. E6 said I asked if R11 was ok and Z1 said yes.

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Z1 said she did not appreciate the way E5 was treating R11. E6 said she reported the incident to the nurses who were in the employee lounge giving report. She said that E19 (Licensed Practical Nurse) E20 (Registered Nurse), Z2 (Agency Nurse), and E21 (nurse) were in the room. 30 minutes had passed since I reported it to them around 7:00 AM, and E5 was still on the floor. I called E1 (Administrator) and told her what happened and she said that E7 had to send E5 home. E5 was also in the room of R14. I know an officer came in to look at R5's knee. He had an abrasion, red marks, looked like a scrape.

On 11/19/13 at 11:00 PM E1 (Administrator) said that on Sunday, she had gotten a call from E7. I told her to call the police and send a report to IDPH. The police came in and talked to the nursing staff and took a picture of R5's knee. The police came back and asked to have E5 return to the facility so he could speak to her. R11's family also reported that E5 had been rough with R11. I wish someone else would have gone to help R11. E5 should have been removed from the floor immediately and not had an opportunity to go care for other residents. (R11, R14) R11 should not have been subject to that. E5(CNA) has been counseled by E2 (Director of Nursing) before, for "mouthing off to the nurses."

On 11/19/13 at 10:15 AM E2 said that she received several calls on Sunday morning. E5 called her and said she was being sent home. She told me she was being sent home, because the nurses were hounding her to leave R5 and take care of another patient. She said she was getting upset and said " Is that patient more important than this one?" The nurses told me they explained to E5 that R11 was having shortness of breath. They wanted him put to bed

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and elevate the head of the bed. She (E5) said that that was not explained to her. She did say she pulled out a drawer and it fell on the floor in R5's room. E5 said Z1 (agency nurse) asked "Is that really necessary?" Z1 told me she heard R5 say "ouch" and she saw out of the corner of her eye, R5 rolling back toward E5. She (Z1) said R5 had a red mark on his knee. Another nurse heard R5 say "ouch" out in the hallway. E2 said R5 is not really verbal, but he knows pain. Nurses told me that they assisted R11 to lay down, not E5. E6 then told me that the family said E5 was rough with him when she put him into the bed. No one saw this it was just reported by the family to E6.

On 11/18/13 at 1:10 PM, Z1 said that on Sunday, a CNA was rough with her dad. She said the CNA came in and was "jerking" her dad around. She started lifting him in the stand lift before he could even hold on. She was in a bad mood. She did not even say a word to him. I was told later that she got sent home.

On 11/18/13 at 1:20 PM, R11 said that she (E5) "was smart with me, she was rude, it was like you'll do it my way or you can go down the road."

A Police Report dated 11/17/13 documents the following: R5 was observed and had a 1.5 inch by 2.5 inch mark/bruise on his right knee. I took two photos of the mark. I then had E7 call E5 back to the facility so I could talk to her. When E5 (CNA) arrived I could tell she was agitated. She spoke loudly and advised me to follow her into the office. We went into the office to talk. E7 was there during our whole conversation.
I asked E5 what happened. E5 said that on more than one occasion that morning her co-workers had asked her to stop dressing R5 and help another resident. E5 repeatedly told them she

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S9999	Continued From page 5 was already busy. E5 said that Z1 had eventually "pushed her button" and caused her to "go off" because they kept asking her to stop helping R5 and go help another resident. E5 advised that she then rolled R5 over on the bed and he hit his knee. I asked her if she thought she maybe was a little too aggressive when she did it because she was upset. E5 said "No, I was f...ing pi..sed." E5 was arrested for battery. (B)	S9999		