

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012157	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2014
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NAME OF PROVIDER OR SUPPLIER LEROY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.510e) 300.610a) 300.1010h) 300.1210b) 300.3240a) 300.3240c) 300.3240f)</p> <p>Section 300.510 Administrator e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities.</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.</p> <p>These requirements are not met as evidenced by:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Based on observation, interview, and record review the facility failed to follow their policy and provide for the safety of other residents after resident to resident abuse occurred, failed to notify the victim's (R5) and the perpetrator's (R4's) physicians for a period of nine hours after the incident occurred, and failed to notify law enforcement of an assault of one resident (R5) by another resident (R4). R4 attempted to suffocate R5, a severely cognitively impaired resident, R5 was not placed on one to one observation as specified in the facility policy, which placed other residents at risk. These failures have the potential to affect all 80 residents in the facility.</p> <p>Findings include:</p> <p>A facility Abuse Prohibition Policy dated as revised 10/2012 documents that, "Special attention will be given to identifying behavior that increased the resident's potential for abusing self or others or being the victim of abuse. These behaviors would include residents with aggressive behaviors,...behaviors such as; entering other residents rooms...residents with communication disorders, and those who require heavy nursing care and/ or are totally dependant on staff." The policy also documents that, "The administration shall immediately contact local law enforcement authorities," for resident to resident physical abuse." The policy documents that following an incident of alleged abuse, "...the Administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated," and that, "...the suspected resident shall be supervised 1:1 or kept physically separated from all other residents until further orders." The policy indicates that, "The shift nurse shall call the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>resident's attending physician."</p> <p>A facility abuse investigation dated 2-24-14 documents that at 1:00a.m. on 2-23-14, "...CNA(Certified Nurse Aide) found R4 lying on top of R5 with (R4's) hands over (R5's) mouth and nose." The investigation documents that R4 was moved to a private room and eventually transferred to the hospital where R4 was diagnosed with Homicidal Ideation.</p> <p>On 2-26-14 at 9:18a.m. E12 (Licensed Practical Nurse) stated that on 2-23-14 after R4 was found with hands covering R5's mouth and nose, R4 was removed from the room and taken to the nurse's station for supervision so E12 could telephone E1 (Administrator). E12 verified that R4 and R5's physicians and families were not called after the incident because E1 told E12, "I'll take care of it in the morning." E12 stated, "I assumed that meant calling the doctor and the family too." E12 stated that during the conversation with E1, E1 was informed that the facility did not have enough staff to keep R4 in 1:1 observation and that E1 stated, "I didn't say 1:1, I said to monitor (R4) closely." E12 stated that during the conversation with E1, E1 also stated, "I already talked to R4's son about R4 and said one more incident and R4 would have to go." E12 verified that following the phone call with E1, R4 was transferred to a private room on another unit in the facility.</p> <p>On 2-26-14 at 10:50a.m. E15 (Certified Nurse Aide) stated that on 2-23-14 at around 1:00a.m. E15 and E18 (Certified Nurse Aide) were near the nurse's station when "yelling" could be heard from down the hall. E15 stated that E18 stopped for gloves while E15 went into R4's room and found R4 on top of R5 with hands covering R5's mouth</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>and nose. E15 stated that once R4 was pulled off of R5, E12 (Licensed Practical Nurse) entered the room and asked R4 if R4 was aware that covering another resident's nose and mouth, keeping them from breathing, could cause serious harm. E15 stated that R4 verified understanding what R4 had done. E15 stated that after R4's hands were taken off of R5's mouth and nose, R5 was not responsive. E15 stated that both E15 and E18 started patting R5's face, rubbing R5's chest, and lifting R5's arms and legs to get R5 to respond. E15 stated, "It was a sight I will never forget. It was a very serious situation...It took me about an hour to calm down."</p> <p>On 2-26-14 at 9:55a.m. E18 (Certified Nurse Aide) stated that when E18 entered R4's room on 2-23-14 at 1:00a.m., E15 (Certified Nurse Aide) had already pulled R4's hands from R5's mouth and nose. E18 stated that R5 did not respond for 20-30 seconds. E18 stated, "I touched R5's face, and rubbed R5's chest... It took 20-30 seconds to arouse R5." E18 stated that R4 had a history of intrusive behaviors which included walking into other residents rooms without permission, "constantly drug seeking," and agitation. E18 stated, "We spent a lot of time baby sitting R4 because of R4's behaviors."</p> <p>On 2-26-14 at 9:00a.m. E17 (Licensed Practical Nurse) stated that 2-23-14 after the incident between R4 and R5, R4 was transferred to E17's care at the end of the hall. E17 stated that when R4 arrived to the new room, R4 was "agitated." E17 verified, "No one sat with R4. We were very limited with staffing and I couldn't pull someone to sit with R4. So between the two CNAs (Certified Nurse Aides) and I, we checked on R4 every 15 minutes."</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>On 2-26-14 at 1:35a.m. E13 (Certified Nurse Aide) stated that on 2-23-14 after the incident, R4 was transferred to the 100 hall where E13 was working. E13 stated that because there was not enough staff available to watch R4, E13 and E14 (Certified Nurse Aide) took turns monitoring R4 every 15 minutes. E13 stated that they decided to block the bathroom from the adjacent room to R4 so R4 could not gain access to that resident's room.</p> <p>On 2-26-14 at 2:35p.m. E10 (Licensed Practical Nurse) verified that E10 telephoned E1 (Administrator) the morning of 2-23-14 just before 10:00a.m. because E1 had not arrived at the facility to decide what to do about R4. E10 stated that while talking to E1, E1 denied any memory of being called by E12 (Licensed Practical Nurse) after the incident occurred between R4 and R5. E10 stated during the conversation with E1, E10 was instructed to notify R4 and R5's physician of the incident, but that E1 also stated R4 and R5's families would be informed once E1 arrived at the facility. E10 stated that R4's physician instructed E10 to transfer R4 to the hospital for evaluation. E10 stated the police were not notified of the resident to resident assault until after 10:00a.m., over nine hours after the incident, when R4 was transferred to the hospital. E10 noted that the police were only notified at that time to protect the safety of the emergency medical technicians transporting R4 to the hospital for a psychiatric evaluation.</p> <p>On 2-26-14 at 2:45p.m. E1 (Administrator) shook head and shrugged shoulders when asked about the facility abuse prohibition policy. E1 verified that E1 could not state what procedures were outlined in the facility's abuse policy, or what</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>actions should be taken following a witnessed abuse situation, stating, "I don't know (what the policy says). I haven't read it for a while." When asked about what situations require law enforcement notification E1 replied, "I don't know. Physical harm?" E1 verified that the facility had had discussions with R4's POA (Power of Attorney) about transferring R4 to a different facility. E1 stated, "I'm sure we talked to (R4's) son about how to make R4 happy, and that might have involved going to another facility."</p> <p>On 2-26-14 at 1:25p.m. E16 (Social Services Director) stated that R4 had had several room changes since arriving at the facility 1-08-14. E16 stated that R4 didn't like roommates who made noise, left lights on, or had visitors. E16 stated that it was E16 who determined that placing R4 and R5 in the same room would, "be a good fit." E10 stated that because R5 was quiet and didn't watch TV, "I didn't think it would be a risk to put R4 in a room with R5"</p> <p>On 2-26-14 at 2:20p.m. Z1 (R4's Physician) verified that R4 should have been placed in 1:1 supervision following trying to suffocate R5. Z1 stated that prior to R4 coming to the facility 1-08-14, R4 had "psych behaviors" and had been admitted to an acute care facility to have R4's medications adjusted. Z1 stated, "I suppose (R4) could have been a danger to other residents..."</p> <p>A Minimum Data Set Assessment (MDS) dated 1-07-14 documents that R5 is severely cognitively impaired requiring total dependence of two or more staff for transfers and bed mobility. The MDS also documented that R5 did not ambulate.</p> <p>(A)</p>	S9999		