Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6006308 | A. BUILDING: ________<br>B. WING ________ | 03/13/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ASTA CARE CENTER OF TOLUCA | 101 EAST VIA GHIGLIERI<br>TOLUCA, IL 61369 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Final Observations | S9999 | | |

Statement of Licensure Violations

300.610a)
300.3240a)
300.3240b)
300.3240d)
300.3240e)

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.

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)

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)

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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

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to recognize four incidents of verbal aggression as potential abuse, resulting in a failure to report and investigate the incidents as required. E7/CNA (Certified Nursing Assistant) was verbally abusive to R19 and E2/DON (Director of Nursing) failed to remove E7 from patient contact during the ongoing investigation. R11 was verbally aggressive toward other residents on three separate occasions, and the behaviors were not reported or investigated. These failures have the potential to affect all 74 residents.

Findings include:

On 3/10/14 at 9:45 AM R19 stated, "(E7) was very, very abusive", "(E7) was right in my face" and "(E7) called me a b****, 'h* and f******* c***." R19 demonstrated, with first and second fingers an inch apart, how occurrence made R19 feel and stated, "made me feel small." R19 reported the incident occurred on 3-7-14. R19 stated E7 is working in the facility, 3 days after allegation was made and no one has discussed this occurrence with R19.

On 3/10/14 at 7:30 AM, E7/CNA was going in and out of resident rooms on B Wing hallway and walking in and out of the Nurses Station.

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Facility Investigation for Allegation of Verbal Abuse, dated 3/10/14, completed by E2 DON/Director of Nursing, documents that on 3/7/14, in the afternoon, E6 CNA/Certified Nursing Assistant reported an allegation of verbal abuse to E5 LPN/Licensed Practical Nurse, E8 Activity Director and to E4 MDS/Minimum Data Set Coordinator witnessing E7 CNA arguing, yelling, cursing and calling R19 names. The investigation documents E4 MDS notified E2 DON on 3/7/14. Investigation also documents, "(E7 CNA) was assigned down a hallway apart from the above resident while an investigation was conducted this morning."

The investigation, dated 3/10/14, documents R19's allegation of E7 arguing with and calling R19 an inappropriate name and states, "After further investigation, a witness was able to corroborate (R19's) allegation that (E7) had been raising her voice towards (R19) and indeed had called (R19) an inappropriate name." The investigation also documents E7 CNA continued to work scheduled shift on 3/7/14 and 3/10/14 after verbal abuse allegation was made known to E5 LPN, E8 Activity Director, E4 MDS and E2 DON.

E7 CNA's Timecard Report, dated 3/7/14, verifies E7 clocked in at 6:20 AM and clocked out at 2:22 PM. E7's Timecard Report, dated 3/10/14, verifies E7 punched in at 6:08 AM.

2. MDS Assessment (Minimum Data Set) dated 2/20/14 for R 11 lists a BIMS (Brief Interview for Mental Status) score of 15, indicating R11 has full cognitive capacity.

Nurse's Note for R11, dated 12/19/13 at 9:30 PM,

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states, "Res(ident) heard yelling at other res(sident) down the hall. Resident cussing at resident and telling him to get out of her 'f****** chair.' Res(ident) continues to be very agitated."

Nurse's Note dated 1/9/14 at 7:30 PM for R11 states, "Resident racing down to roommate door. Resident yelling and cussing. Resident in smoking shed and got into disagreement with another resident in the shed. When resident coming back cussing and threatening. Res stated, 'Would punch other resident in eyes.' "

Nurse's Note dated 3/2/14 at 6:55 PM for R11 states, "Resident heard yelling at male resident from another hall to get off of 'A' hall, that is 'my hall' and 'If I catch you in my room I will break your f****** fingers. Resident told writer nurse to 'shut the f*** up and stay out of it.' Resident continued to yell and holler at male resident."

On 3/12/14 at 10:30 AM, E2/DON (Director of Nursing)/Abuse Coordinator stated that she was not aware of the incidents on 12/19/13, 1/9/14 and 3/2/14 or she would have investigated these incidents as abuse.

Resident Census and Conditions of Residents, dated 3/10/14, documents facility census at 74 residents.

(B)