

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000624</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/07/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TURNER MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946</b>
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Z9999	<p><b>FINDINGS</b></p> <p>Statement of Licensure Violations:</p> <p>350.620a) 350.1210 350.1220j) 350.3240a) 350.3240b) 350.3240e)</p> <p>Section 350.620 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1220 Physician Services</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not 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.</p>	Z9999		
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Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Z9999	<p>Continued From page 1</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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)</p> <p>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)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse/neglect for 1 individual (R1), and failed to train the direct care staff on the appropriate way to report an allegation of abuse or neglect in a timely manner, and failed to implement their own policy and procedures prohibiting abuse and neglect when staff of the</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>facility failed to:</p> <ul style="list-style-type: none"> <li>* Promptly report an allegation of pornography of a disabled person when a licensed practical nurse (E4 - LPN) was seen taking a picture of R1's genitalia while he was laying in bed, naked from the waist down;</li> <li>* Immediately bar E4 (LPN) from further client contact upon becoming aware of the allegation;</li> <li>* Provide reproducible documentation that R1 was immediately assessed once the oncoming nursing staff become aware of the allegation; and</li> <li>* Immediately initiate an investigation regarding the allegation of pornography of a disabled person (R1).</li> </ul> <p>Findings Include:</p> <p>Review of the facility form "Residents Statistics 2013" (undated) documents R1 is a 28 year old male who functions at a Severe level of Intellectual Disability.</p> <p>Review of the facility policy "Client Protections; abuse and neglect" dated 8/9/11 states, "All nursing and DSP (direct support person) will complete the Abuse and Neglect section of the DSP training program at the time of hire and annually thereafter. In the event a staff member observes injury to or mistreatment of clients of any nature a or if ANY inappropriate staff to consumer interaction is observed, the observing staff member will first insure (sic) that the alleged abuser is immediately separated from consumer contact (asked to leave programming areas) or is immediately paired with another DSP and not left</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>alone with any consumers. The reporting staff member will then immediately notify the nurse on duty." This policy does not address who a direct support person is to report an allegation of abuse to if the perpetrator is the nurse on duty.</p> <p>Review of employee records documents new employees sign an "Acknowledgement Form Reporting Abuse/Neglect Allegation." This form states, Also DPH (handwritten in at the top of the form) I have been given a copy of the agency's policies and procedures for reporting abuse/neglect allegations and have read it and understand its contents. I know that I am bound by the state regulations to report any incidents of suspected abuse and neglect to the Office of Inspector General. I know that if I have any questions about this policy I can call the Human Rights Officer at (listed phone number).</p> <p>During interview on 4/23/14 at 2:48 PM E9 (Direct Support Person-DSP) stated when asked about reporting allegation of abuse/neglect. "Report it with in two minutes or less. I would tell the QA (DSP shift supervisor) if they were not here I would tell the nurse. If it was the nurse I would find a way to make a phone call to call the QA or the hotline (not specified) even."</p> <p>During interview on 4/23/14 at 2:56 PM E7 (DSP) stated when asked about reporting allegations of abuse/neglect. " Contact E1 (Administrator) or E2 (QIDP-Qualified Intellectual Disability Professional) or E3 (Nursing Supervisor) and a hotline (not specified) number." When asked where the number was posted E7 stated, "I don't know it is in a book somewhere. You contact way before 24 hours, within the first few minutes."</p> <p>E12 (DSP) was interviewed on 04/23/14 at 2:20</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>P.M. During the interview with E12 when asked about the facilities policy for abuse reporting, he stated, "Took way too long to report." When E12 was asked about what took too long to report he stated that he was referring to the recent incident about the nurse taking pictures of R1.</p> <p>The facility's policy for Client Protections, Subject: Abuse and Neglect with a revision date of 08/09/11 states that the facility is, "... committed to ensuring that clients of the facility are not subjected to physical, verbal, sexual, or psychological abuse or punishment. Individuals must not be subjected to abuse by anyone, (including but not limited to, facility staff...). This policy goes on to state that:</p> <p>* In the event a staff member observes injury to or mistreatment of clients of any nature or if ANY inappropriate staff to consumer interaction is observed, the observing staff member will first insure that the alleged abuser is immediately separated from consumer contact (asked to leave programming areas) or is immediately paired with another DSP (Direct Support Person) and not left alone with any consumers.</p> <p>* The reporting staff will then immediately notify the nurse on duty.</p> <p>* The nurse on duty will immediately confirm that the alleged abuser has no opportunity for unsupervised consumer contact and will then assess the consumer for injury...</p> <p>* The nurse will immediately initiate an investigation and notify the Administrator and RSD (Resident Services Director)/Human Rights Officer.</p>	Z9999		

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Z9999	<p>Continued From page 5</p> <p>* The Administrator or RSD will ensure notification of the guardian, physician, or other relevant professionals.</p> <p>*The nurse will ensure completion of a written incident report and initiate a 24 hour follow up report...</p> <p>* When a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee is the perpetrator of the abuse, the QMRP (Qualified Mental Retardation Professional) or Charge Supervisor will ensure that employee is immediately barred from contact with facility consumers pending the outcome of any further investigation, prosecution or disciplinary actions against the employee.</p> <p>In review of the facility's Investigative Case Summary regarding the allegation of 04/13/14 it is identified that,</p> <p>Allegation/Complaint: "... a DSP (unidentified) witnessed E4 (Licensed Practical Nurse/LPN) taking a photo of a male client (unidentified) who was not wearing any clothing.</p> <p>Guardian, Administrator, DON (Director of Nursing), IDPH (Illinois Department of Public Health) and the Harrisburg Police Department were notified...</p> <p>Summary of Evidence: Following a call from DSP E6, E2 (QIDP-Qualified Intellectual Disability Professional) interviewed DSPs E6, E17, E5, E26, E15 and E27.</p> <p>E6 (DSP) called and reported to E2 (QIDP) that DSP (E17) reported an unusual incident that</p>	Z9999		

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Z9999	<p>Continued From page 6</p> <p>happened on her shift. She (E17) stated that she was told that E4 (LPN) took a "naked" picture of Consumer R1 without any medical reason that she could determine.</p> <p>E17 (DSP) reported that at approximately 9:00 P.M. on 04/13/14 she was in consumer's R1's room when E4 (LPN) entered. E17 left to go down the hall and return a note book. Upon her (E17's) return (she was gone less than 5 minutes) she noted E4 was taking a picture of consumer R1. She (E17) inquired as to why and E4 showed her the picture of R1 and stated that, "Pictures of big balls and butts turn her (E4) on". She (E17) stated that E4 was not alone with any clients for the 1 hour remaining on her shift. She (E4) remained at the nurse's station. She (E4) did not work 04/14/14.</p> <p>E5 (DSP) stated that she was shown what appeared to be a picture of R1 by E4. It was of his unclothed buttocks and testicles. She (E5) did not see her (E4) take the picture but E4 stated that, "Big balls and butts turn her on."</p> <p>E26 (DSP) stated that she did not see or hear anything notable.</p> <p>E15 (DSP) said she heard E4 (LPN) say, "Shi**y d**ks and balls turn her on" but didn't see her take any pictures and was not shown any.</p> <p>E27 (DSP) said she did not see or hear anything notable..."</p> <p>Review of the facility "Investigative Case Summary" documents on "4/13/14 a DSP (direct support person-unidentified) witnessed E4 (Licensed Practical Nurse-LPN) taking a photo of a male client (unidentified) who was not wearing</p>	Z9999		
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Z9999	<p>Continued From page 7</p> <p>any clothing...E17 (DSP) reported that at approximately 9:00 PM on 4/13/14 she was in consumer R1's room when E4 entered. E17 left to go down the hall and return a notebook. Upon her return (she was gone less than five minutes) she noted E4 was taking a picture of R1. She inquired as to why and E4 showed her the picture of R1 and stated that "Pictures of big balls and butts turn her on."</p> <p>Further review of this facility's investigation identifies that the local police department was notified on 04/14/14 of E4's action and that she (E4) was arrested for Child Pornography. This report also states that, "As a reminder all staff were in-serviced on the facilities abuse, neglect and mistreatment policy as well as the media policy including prohibition on taking pictures of consumers.</p> <p>Z1 (Local Police Officer) was interviewed on 04/23/14 at 12:46 P.M. and stated that E4 was arrested on 04/14/14 and charged with Child Pornography. When Z1 was asked why the charge of Child Pornography he stated, "That statutes within the Child Pornography laws cover individuals with disabilities since these individuals usually cannot give consent." Z1 stated that a search warrant was issued for E4's cell phone and the picture in question of R1's genitalia was found in a saved file on E4's phone. Z1 provided the surveyors with a copy of the police case file report regarding this incident during this interview.</p> <p>In review of the facility's investigative summary report (for the allegation occurring on 04/13/14) does not identify: when staff (E6 DSP) reported</p>	Z9999		
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Z9999	<p>Continued From page 8</p> <p>this allegation to E2 (QIDP); if R1 was assessed by nursing staff (E28) after becoming aware of this allegation on 04/13/14; if E4 was immediately barred from further client contact after staff saw her taking and/or saw the pictures of R1's naked genitalia; and/or that the facility immediately began an investigation after becoming aware of the allegation of pornography of a disabled person.</p> <p>On 04/22/14 at 4:11 P.M. E2 (QIDP) confirmed that E17 DSP did not contact her until the day after the incident when she stated, "I did not receive a call from E17 (DSP) until 10:00 A.M. the next morning (04/15/14) after the incident (04/14/14).</p> <p>E17 (DSP) was interviewed on 04/22/14 at 3:15 P.M. via telephone and stated, " I was in R1's bedroom and he was asleep on 04/14/14. E4 (LPN) was in the middle of her med pass and I ran to turn in a book. When I returned to the bedroom, E4 had her phone turned sideways taking a picture of R1. I asked her what are you doing? And she showed me the picture of R1 naked and asked me if that turned me on. I knew I needed to report it but I didn't have E2's number. I talked to E6 (DSP) and she was to tell E28 (LPN) when she came in between 10:30 - 11:00 P.M. I did call back later to make sure that E6 (DSP) told E28 (LPN) and I called E2 (QIDP) the next day." When E17 was asked what the facility's policy is for reporting abuse and/or mistreatment she stated, "You are to notify the QA-Qualified Intellectual Disability Professional Assistant, and if there is no QA person then you are to tell the nurse. Well, if the nurse is the person you're reporting then you have to call somebody but I didn't know who to call." E17 was then asked if E4 (LPN) had any further resident</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>contact after she took the picture of R1 and she stated, "No, she went and sat at the nurse's station until I left. I clocked out at 10:00 P.M.. I wasn't there when E4(LPN) left the facility."</p> <p>E8 (QA-Qualified Intellectual Disability Professional Assistant) was interviewed on 04/22/14 at 4:20 P.M. and stated, "There is a QA person everyday except Sundays and Mondays after 8:00 P.M." When E8 was asked what staff are to do if a QA person is not present and the nurse is suspected of abuse, he stated, "Staff are to call E2 (QIDP) or E1(Administrator). E8 was then asked what staff are to do if they can not leave there assignment to report abuse and he stated, "They can use their cell phone, or they should get a relief person to cover for them. There are always two people in the hallways at night. Phone numbers are posted on the doors of the cluster rooms, at the nurse's station and all over the building.</p> <p>E6 (DSP) was interviewed on 04/22/14 at 3:30 P.M. via telephone and stated, "A friend (E17-DSP) had a problem and she talked to me about it when I was clocking in at 10:10 P.M. She stated that she (E17-DSP) caught the nurse (E4) taking pictures of R1 for her collection and told her that stuff turned her on. E17 (DSP) didn't know what to do because there was no QA person and the only nurse working was E4. I told E28 (LPN) about what E6 told me a little bit after 11 P.M. when E4 (LPN) wasn't around. E28 (LPN) called E2 (QIDP) that night and I think E17 (DSP) called E2 (QIDP) the next day."</p> <p>During an interview with E15 (DSP) on 04/23/14 at 3:11 P.M. she confirmed that she was present and worked the evening of 04/14/14. In this interview E15 stated that after E4 (LPN) took the</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p>picture of R1, she (E4) continued to pass medications to other individuals of the facility. E15 stated, "I worked that night (04/13/14). I heard E4 (LPN) talking with E27 (DSP) about, "shi**y d**k and balls" when I was doing bed checks." When E15 was asked what E4 did after talking with E27, she stated, "She continued passing medications because she wasn't finished with her medication pass. She (E4/LPN) was between R4's and R1's bedrooms. E6 (DSP) told me that she had walked in on E4 (LPN) taking pictures of R1 and I told her (E6) that she need to report it. I don't know what happened after that because I got off at 10:00 P.M." E15 was then asked what is the facility's policy for abuse reporting and she stated, "At the time that we were hired we were told that if you see or witness abuse that you are to report it to the nurse." E15 went on to say, "If the nurse is the person that you are reporting and no one else is there (no QA), what do you do?"</p> <p>In review of E4's Time Card for the date of 04/13/14, E4 continued working the remainder of her shift and did not clock out until 00:15 hour (12:15 A.M.) E28 as confirmed per telephone interview with E1 (Administrator) did not clock into work on 04/13/14 until 23:45 (11:45 P.M.)</p> <p>There is no documentation within the facility's investigative summary report indicating that E4 (LPN) was interviewed by staff of the facility on 04/13/14 as part of the facility's prompt investigation process. E4 worked the remainder of her shift and the facility does not have reproducible documentation showing that safeguards were immediately implemented to prevent further potential abuse after staff of the facility became aware that E4 (LPN) had taken an explicit picture of R1's genitalia with her cell</p>	Z9999		

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(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
Z9999	<p>Continued From page 11 phone.</p> <p style="text-align: center;">(A)</p> <p>350.620a) 350.1210 350.1220j) 350.1220k) 350.3240a) 350.3240b) 350.3240c) 350.3240d)</p> <p>Section 350.620 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1220 Physician Services</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000624</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/07/2014</b>
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Z9999	<p>Continued From page 12</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not 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.</p> <p>k) At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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)</p> <p>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. (Section 3-610 of the Act)</p> <p>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)</p>	Z9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000624</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/07/2014</b>
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Z9999	<p>Continued From page 13</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, 1) the facility failed to thoroughly investigate an allegation of abuse/neglect for 1 (R2) and failed to investigate a significant incident (fall) for 1 individual (R2) and failed to provide nursing services for 1 individual (R2).</p> <p>Based on interview and record review the facility failed to provide nursing services for 2 (R2 and R3) individuals when they failed to:</p> <ol style="list-style-type: none"> <li>1. Promptly assess and report when R2 was witnessed on the floor of his room, had a low sugar episode, became combative.</li> </ol> <ul style="list-style-type: none"> <li>* Thoroughly assess and document R2 after he was found on the floor in his bedroom by staff.</li> <li>* Investigate after R2 was found on the floor and had a low blood sugar episode that resulted in him becoming combative.</li> <li>* Assess and obtain treatment for R2 when he continued to complain of left leg pain for several days. R2 was assessed at the emergency room and diagnosed with a hip fracture.</li> </ul> <ol style="list-style-type: none"> <li>2. Assess and document after R3 had seizure activity that resulted in R3 being sent to the emergency room and admitted to special care unit.</li> </ol>	Z9999		

Illinois Department of Public Health

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Z9999	<p>Continued From page 14</p> <p>Findings Include:</p> <p>1) Review of the facility "Resident Statistics 2013" (undated) document R2 is a 45 year old male who functions at a Severe level of Intellectual Disability.</p> <p>Review of the facility "Initial Report of Incident" dated 4/21 states "R2 went to (name of doctor) who sent him to ER (emergency room) for ultrasound related to possible blood clot. ER determined that he has a hip fracture. Transferred to (name of regional hospital) for hip surgery, scheduled for 4/22/14 in am.</p> <p>During interview on 4/23/14 at 11:02 AM, E17 (DSP) stated, R2 had a fall 2-3 weeks ago. R2 was found in the floor and assessed by E21 (Licensed Practical Nurse-LPN). Incident reports were filled out by E26, E5, and E7 (DSP's).</p> <p>During interview on 4/23/14 at 4:00 PM, E5 (DSP) stated, "I cannot remember the date but R2's sugar dropped and R2 freaked out. I wasn't in there when he fell. They called me to help calm him down. I helped take him to the bathroom. We transferred R2 to a wheelchair and crossed his arm ...so he wouldn't hurt himself or someone else. We (E26, E29 and E17) filled out an incident report. E21 (LPN) assessed R2."</p> <p>During interview on 4/23/14 at 4:35 PM, E21 stated she remembered R2 having a low blood sugar episode and being wet. "R2 became combative and they hollered for help. We got him out of the bathroom and was holding him down "not hard." I would have documented it on the hot sheet or in the nurses notes." I do remember they (direct support staff) turned in paperwork to me because they were afraid they were going to get</p>	Z9999		

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Z9999	<p>Continued From page 15</p> <p>in trouble."</p> <p>During interview on 4/24/14 at 1:10 PM E1 (Administrator) stated, " We can't find an incident report related to the night R2 fell and was combative and the restraint record was not filled out."</p> <p>On 4/24/14 at 10:21 AM E1 (Administrator) stated she found the 24 hour report for R2's incident.</p> <p>Review of the facility "24 shift follow up" for R2 dated 3/30/14 documents at 8:45 PM "R2 was found in the floor in his room. Assisted him (R2) to BR (bathroom) when he became combative. Checked his BS (blood sugar) 27 gave him glucose gel to raise it. After getting him back to bed. Did assessment several scratches and scrapes found. 4:45 AM areas remain present at this time no s/sx (signs or symptoms) of diabetic crises. 12:45 PM remain c (with) scratches. 8:45 remain c (with) scratch to forehead et (and) shoulders no outward s/s (signs or symptoms) of pain or distress noted."</p> <p>Review of DSP (direct support person) Incident/Accident Report Form documents on 3/30/14 8:45-9:15 "R2 found on the floor with scratches on face and head. When trying to toilet he started hitting, kicking, and jumping. We (E5, E26, and E17) had to ...keep him in wheelchair. Sugar was checked in bathroom and was low." This form was signed by E17 (DSP) and E21 (Licensed Practical Nurse).</p> <p>The facility was unable to produce documentation related to the restraint that was used for R2 on 3/30/14. There is no documentation that the physician or guardian was notified of R2 being</p>	Z9999		



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Z9999	<p>Continued From page 16</p> <p>restrained.</p> <p>Review of the local hospital's Radiology Transcription Report dated 4/21/14 for R3 documents under findings; "There is an acute transverse subcapital fracture of the left femoral neck with lateral displacement of this component by at least 75% to 80% with external rotation. Suggestion of associated lucent lesion of bone and therefore pathological fracture is to be considered."</p> <p>Review of the facility "Nurses Notes for R2" documents on:</p> <p>* 4/19/14 at 9:30 AM 122/74 (blood pressure) 86 (pulse) Seated within cluster this a.m. Refused breakfast meal but did consume alternative sandwich. Has cried most this a.m. et (and) appears unconsolable (sic). Admin (administered) PRN (as needed) pain med (medication) Norco 7.5/325 mg (milligrams) 1 po (by mouth) accepted s (without) difficulty FLACC (pain) scale completed MAR (medication administration record) update. Will cont (continue) to monitor."</p> <p>* 4/20/14 not timed V/S (vital signs) 98.7, 118/72, 96, 20, SPo2 97% R/A (room air). Consumer crying steadily. c/o (complaints of) L (left) knee pain- appears slightly swollen. No known aggravation. While c/o knee able to rest R (right) leg over L (left). PRN (as needed) pain med (medication) admin (administered) accepted s (without) difficulty. Staff assisted to recliner within cluster et (and) is currently resting c (with) legs elevated. 9:45 AM Will cont (continue) to monitor.</p> <p>* 4/21 3p (PM) OOF (out of facility) c (with) staff x (times) 2 via facility van to PCP (primary care physician) r/t (related to) swollen knee.</p> <p>* 4/21 4p (PM) Received call from (name of</p>	Z9999		

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Z9999	<p>Continued From page 17</p> <p>doctor) sending R2 to ER (emergency room) r/t (related to) possible blood clot and requested copies of DNR (do not resuscitate) be faxed to him and the ER.</p> <p>* 4/21 7:50 PM Called (name of local hospital) ER (emergency room) and spoke to (name of RN-registered nurse) she stated he had a fractured hip that was "very broken." He is being transferred to (name of regional hospital)...c (with) surgery scheduled in am of 4/22/14."</p> <p>Prior to the nurses note entry of 4/19/14 there is no documentation in the nurses notes related to pain or discomfort in R2's left leg.</p> <p>Review of R2's pain scale dated 4/19/14 9:30 AM and 4/20/14 8:45 AM documents R2's pain scale was 8-10 severe pain.</p> <p>Review of R2's PRN (as needed) Medications document R2 received Norco 7.5/325 milligrams for pain on 4/19/14 at 9:30 AM and on 4/20/14 at 8:45 AM.</p> <p>Review of facility incident reports did not document an incident for R2.</p> <p>During interview on 4/22/14 at 4:30 PM E13 (Direct Support Person-DSP) stated, "I took R2 to the doctor. The doctor looked at the leg and told me he was sending us to the emergency room because he was afraid R2 had a blood clot. R2 had complained of pain in the left leg for about a week. R2 moved the leg and was standing on it at the doctors office. R2 was found on the floor during 8-10 shift a week and a half or two weeks ago. I heard that from E17 (DSP)."</p> <p>During interview on 4/23/14 at 11:02 AM E17 (DSP) stated, R2 had a fall 2-3 weeks ago. R2</p>	Z9999		
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Illinois Department of Public Health

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Z9999	<p>Continued From page 18</p> <p>was found in the floor and assessed by E21 (Licensed Practical Nurse-LPN). Incident reports were filled out by E26, E5, and E7 (DSP's).</p> <p>During interview on 4/23/14 at 4:20 PM, E1 (Administrator) stated; "We cannot find record of an incident for R2 during the last of March or first of April."</p> <p>During interview on 4/23/14 at 4:20 PM, E1 (Administrator) stated she was unable to find an incident report on R2 since he fractured his toe in November or December.</p> <p>During interview on 4/24/14 at 12:38 PM E20 (DSP) stated R2 had complained of knee pain and E2 remembered the nurse giving R2 Tylenol about a week and a half ago.</p> <p>During interview on 4/24/14 at 12:10 PM E18 (DSP) stated R2 complained of left leg pain a week prior to him going to the hospital and being diagnosed with a fractured hip.</p> <p>During interview on 4/24/14 at 1:10 PM E1 (Administrator) stated, " We can't find an incident report related to the night R2 fell.</p> <p>During interview on 4/24/14 at 10:57 AM Z5 (Orthopedic Surgeon) stated R2's fracture did not look like a fresh fracture. Z5 couldn't put a specific time frame on it but when asked if it could have occurred with a fall approximately three weeks ago Z5 stated "that is very plausible."</p> <p>Review of the facility "Policy for Notification on Consumer Incident/Accidents/Illness dated 8/2/07 documents, "If a consumer has anything other than a minor cut/scrape/abrasion or minor fall</p>	Z9999		

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Z9999	<p>Continued From page 19</p> <p>with no injury the following policy should be followed:</p> <ol style="list-style-type: none"> <li>1. Notify the MD (medical doctor) by phone...</li> <li>2. We will no longer fax the doctor</li> <li>3. Notify the DON (director of nurses)</li> <li>4. Notify the Administrator</li> <li>5. Notify the Guardian...by phone- leave a voicemail...</li> <li>6. Notify IDPH (Illinois Department of Public Health)</li> </ol> <p>Review of the facility "Policy Client Protections: Investigation of Incident dated 8/9/11 documents the following: The investigation will begin immediately by the nurse and/or supervisory staff on duty and follow-thru will continue until investigation is complete."</p> <p>Review of the facility "Policy Client Protections: Serious Incidents and accidents" dated 8/9/11 documents "The facility shall notify the Department of any serious incident or accident that causes physical harm or injury to a resident....The DON (director of nurses) will maintain copies of reportable incidents and accidents that is not the expected outcome of a consumer's condition. A descriptive summary of each incident or accident shall also be recorded in the progress/nurses notes of each resident."</p> <p>On 4/24/14 at 10:21 AM E1 (Administrator) stated she found the 24 hour report for R2's incident.</p> <p>Review of the facility "24 shift follow up" for R2 dated 3/30/14 documents at 8:45 PM "R2 was found in the floor in his room. Assisted him (R2) to BR (bathroom) when he became combative. Checked his BS (blood sugar) 27 gave him glucose gel to raise it. After getting him back to bed. Did assessment several scratches and</p>	Z9999		

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Z9999	<p>Continued From page 20</p> <p>scrapes found. 4:45 AM areas remain present at this time no s/sx (signs or symptoms) of diabetic crises. 12:45 PM remain c (with) scratches. 8:45 remain c (with) scratch to forehead et (and) shoulders no outward s/s (signs or symptoms) of pain or distress noted."</p> <p>Review of DSP (direct support person) Incident/Accident Report Form documents on 3/30/14 8:45-9:15 "R2 found on the floor with scratches on face and head. When trying to toilet he started hitting, kicking, and jumping. We (E5, E26, and E17) had to ...keep him in wheelchair. Sugar was checked in bathroom and was low." This form was signed by E17 (DSP) and E21 (Licensed Practical Nurse).</p> <p>The facility did not have reproducible evidence that:</p> <ul style="list-style-type: none"> <li>* An investigation had been completed for the incident of 3/30/14 when R2 was found on the floor, had a low blood sugar episode that resulted in R2 becoming combative.</li> <li>* There was no evidence of a full body assessment being completed by the nursing staff to ensure there were no injuries related to the fall.</li> <li>* There was no evidence of the physician or guardian being notified of the fall.</li> <li>* There was no evidence of full body assessments or notification of physician and guardian once R2 began to complain of pain in the left leg</li> </ul> <p style="text-align: center;">(B)</p>	Z9999		



## IMPOSED PLAN OF CORRECTION

TURNER MANOR

DATE OF SURVEY: 05/07/2014

- 350.620a) The facility shall ensure that its policies for preventing, reporting and  
350.1210 investigating abuse are followed.  
350.1220j)  
350.3240a) The facility shall implement measures to ensure that its residents are protected  
350.3240b) from any abuse or neglect by their owners, licensees, administrator, employees or  
350.3240e) agents.

Facility employees who become aware of abuse or neglect shall IMMEDIATELY report the matter to the administrator.

The facility shall bar any employee from contact with residents pending the outcome of a complete investigation whenever an initial investigation of suspected abuse, based on credible evidence, indicates that the employee is a perpetrator of abuse.

This will be accomplished by:

- I. A committee shall be established to review existing policies and procedures concerning abuse and neglect, and to formulate or revise any needed policies and procedures that facility staff will follow. This committee will ensure that the facility's policies and procedures address at a minimum, the following items.
  - A. Recognition of situations that could be interpreted as abuse or neglect;
  - B. Proper reporting procedures for staff to follow;
  - C. Techniques to be utilized in the facility's internal investigation of the situation.
  - D. Notification of local law enforcement when appropriate.
  - E. Disciplinary or precautionary action to be taken with any employee suspected of involvement in an abusive or neglectful act.
- II. All staff will be trained, by mandatory inservice, in the facility's policies and procedures concerning abusive situations. This inservice shall include, but not be limited to:

- A. A thorough review of the facility's revised policies and procedures concerning abuse and neglect;
  - B. Identification of situations which can be considered abuse or neglect;
  - C. Each employee's individual duty to report any abusive and neglectful situations to the administrator. In the administrator's absence, the employee will report to the previously designated supervisory employee who will then report to the proper authority; and
  - D. Disciplinary or precautionary action to be taken against employees suspected of abuse or neglect, or any employee who was aware of any abusive or neglectful situation but failed to report it.
- III. All allegations of resident abuse or neglect will be investigated per the facility policies and procedures.
- A. Incident reports will be reviewed by the QSP (Qualified Support Personnel) and QA (Quality Assurance) Facilitator to ensure that allegations of neglect or abuse are properly investigated.
  - B. The Administrator will also review incident reports to further ensure that all necessary follow up is initiated.
- IV. The facility will take the following actions to prevent reoccurrence of abuse or neglect.
- A. Staff will have the above inservice repeated on a regular basis.
  - B. All new employees will have this information presented to them during their orientation.
  - C. The administrator will take immediate action, in accordance with the established policies and procedures, against any employee who is suspected of abusing or neglecting a resident.
  - D. Appropriate disciplinary action will be taken against any employee who becomes aware of and fails to properly and immediately report an abusive or neglectful incident.
  - E. Any employee suspected of abuse or neglect will be immediately suspended and/or barred from any further contact with residents of



the facility pending full investigation by the facility and/or local law authorities (if warranted).

- IV. The administrator shall be responsible for implementing facility policies and procedures regarding abuse and neglect, and for ensuring this plan of correction is followed.

COMPLETION DATE: All items to be completed within two days of receipt of this Imposed Plan of Correction, with the exception of item III. ,which should be completed within 30 days of receipt of this Imposed Plan of Correction.