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	IL6009989	A. BUILDING: _____ B. WING _____	C 08/14/2018

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OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

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S 000	Initial Comments Complaint Investigation 1815138/IL104771	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610c)2) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 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. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental	S9999	**Attachment A** **Statement of Licensure Violations**	

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services, and diagnostic services (including laboratory and x-ray);

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest

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practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to safely intervene to a resident's catastrophic reaction to care, this failure resulted in a resident receiving multiple large bruises and a hematoma to both the resident's arms.

This applies to 1 of 3 residents (R1) reviewed for abuse in a sample of 3.

The findings include:

On August 8, 2018 at 11:10 AM, R1 was sitting in R1's wheelchair in a common television (TV) area at the facility, wearing a cardigan to cover her arms. A large light purple bruise covered the back of R1's hand. This writer asked R1 about the bruise on R1's hand and R1 tried to pull up the sleeves on R1's cardigan and stated, "They go all the way up." R1 said, "They (the bruises)

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came from someone that scratched me." R1 continued to say, "The woman that did this is still here, but I don't think she has a room." R1 self-propelled the wheelchair back to R1's room and V4, Licensed Practical Nurse (LPN), assisted R1 to remove the cardigan. R1 had bruises on both forearms. R1 had a large bruised area from R1's right wrist, extending up to the middle of R1's forearm. This large bruise had varying colors of black, dark and light purple, surrounded by a faint line of green/yellow discoloration. The top of R1's left wrist had a baseball sized bruise with light purple and green discoloration. The back of R1's left upper forearm, just below R1's elbow, had a golf-ball sized deep purple/black hematoma. R1 touched the hematoma to the left upper forearm and stated, "That one hurts if I touch it." R1 said, "I was scared so bad!" R1 shook R1's head and looked down at the floor. R1 continued to say, "I told them to get out of here; this is my room!" R1 said, "it happened at night time."

On August 8, 2018 at 1:40 PM, R1 self-propelled R1's wheelchair up to this writer in the hallway and said, "Are you the one that is going to find out who did this to me (holding up her arms), I want to know."

On August 9, 2018 at 9:48 AM, V13, Certified Nursing Assistant (CNA) said she did R1's shower on Friday, August 3, 2018 after breakfast. V13 stated, "[R1] had no bruises then." V13 said V13 completed the skin check sheet with the shower on August 3, 2018.

The facility's Skin Check sheet signed August 3, 2018 by V13 shows no skin issues.

On August 8, 2018 at 2:50 PM, V14 (CNA) said

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V16, Registered Nurse (RN), told me that R1 was trying to get R1's self in bed on the evening of August 3, 2018. V16 said V16 started getting ready to provide bedtime care and R1 was fine. V14 said R1 didn't have a clean nightgown of R1's own, so V14 set out a green facility gown. V14 said R1 didn't want to wear the green facility nightgown and started yelling, "Help! She's trying to kill me!" V14 said V15 (CNA) came in after V15 heard the yelling. V14 said V15 asked R1 what was wrong and showed R1 the inside of R1's closet to verify R1's nightgowns were not in the closet. V14 said R1 started thrashing around in R1's wheelchair and cussing at V14 and V15. V14 said they explained to R1 that R1's nightgowns were in the laundry and would be washed first thing in the morning. V14 said R1 calmed down and agreed to wear the green facility nightgown for one night. V14 said V14 and V15 attempted to remove R1's shirt and R1 "freaked out" again. V14 said R1 was kicking, punching, and cussing at us (V14 and V15). V14 said they (V14 and V15) backed away from R1's wheelchair to try to calm R1 down, but R1 tried to get up out of the wheelchair by R1's self. V14 said, "So V15 and I did a two assist transfer from the wheelchair to the bed. R1 was kicking, punching, biting, pinching, and yelling the whole time. V14 said, "[R1] pinched me (showing this writer a small pea sized bruise on her right, inner, upper arm). V14 said I also have several bruises to my legs. V14 continued to say, once R1 was in bed R1 started to settle down a little. V14 said they were able to finish bedtime care, place the green facility nightgown, and cover R1 with blankets. V14 said when I started to leave R1's room, R1 started yelling and cussing at me again. V14 was asked what interventions should be used when a resident is agitated. V14 said, "I honestly don't know what I was thinking (during

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the incident with R1); it just got so crazy I couldn't hear myself think."

On August 8, 2018 at 2:25 PM, V15 (CNA) said V14 went into R1's room first. V15 said V15 heard yelling coming from R1's room, so V15 went in R1's room. V15 said R1 told V15 that V14 wouldn't give R1 "R1's own gown." V15 said V15 opened R1's closet and showed R1 that there were no clean nightgowns in the closet. V15 said V15 offered to look for a different gown, but R1 started yelling. R1 said to V15 that it was strange R1's nightgowns were not in the closet. V15 said V15 told R1 that the nightgowns were in laundry and would be washed in the morning. V15 said R1 calmed down and let V14 and V15 remove R1's shirt. V15 said then R1 started flailing R1's arms around and hitting R1's arms on the wheelchair. V15 said V14 and I decided to two assist R1 to get R1 in bed because R1 refused to stand or get in bed. V15 said R1 started kicking, swinging, punching, and pinching. V15 said, "[R1] was freaking out and throwing a tantrum because we didn't have R1's "own" gown." V15 said, "I have sixty hours of dementia training." V15 said in training V15 learned when a resident is agitated some of the following interventions can be attempted: Try to redirect the resident; change or switch out CNAs; or walk away and give the resident time to calm down.

On August 8, 2018 at 1:43 PM, V16, Registered Nurse (RN), said V16 administered R1's medications at dinner time, but hadn't done any assessments on R1 the evening of August 3, 2018. V16 said I know the CNAs had a hard time getting R1 to bed. V16 said R1 didn't have R1's own nightgown so R1 was giving the CNAs trouble. V16 said V16 did not go in R1's room during the incident with R1. V16 said when R1

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gets agitated, you just have to leave R1 alone.

On August 9, 2018 at 8:37 AM, V11 (CNA) said when V11 got R1 dressed the morning of August 4, 2018, V11 noticed the bruises on R1's arms. V11 said V11 told R1 those are "horrible bruises;" what happened to you? V11 said R1 didn't remember what happened. V11 said V11 reported the bruises to V4, LPN, right away. V11 said, "I've never had any problems with [R1]." V11 said, "I've seen [R1] agitated before; nothing much calms R1 down, except giving R1 space, if [R1] is safe and re-approaching later."

On August 8, 2018 at 11:21 AM, V4 (LPN) said V4 wasn't sure how R1 got the bruises on R1's arms. V4 said I worked the morning of August 4, 2018; saw R1's bruised arms; completed a Skin Check Sheet; left a message for R1's Power of Attorney (POA); notified R1's Nurse Practitioner (NP); and notified V1 (Administrator). V4 said I asked R1 what happened and R1 said, "A lady did it." V4 said R1 just gets more agitated if you try to do things when R1's agitated. V4 said I usually just leave R1 alone for a while and try to re-approach later.

The facility's Skin Check sheet completed by V4 on August 4, 2018 shows R1 has a "5.5 centimeters (cm) x 3 cm" bruise to the back of R1's right hand; "4 cm x 2 cm" bruise to R1's right wrist; and a "13 cm x 8 cm" bruise to R1's right forearm.

The facility's Skin Check sheet completed by V5, Administrative Nurse, on August 5, 2018 shows R1 has a "4.1 cm x 4.0 cm dark" area to back of right hand; "3.8 cm x 5.5 cm dark" area to the right wrist; "12 cm x 10.5 cm dark" area to right forearm; "0.4 cm x 0.4 cm, 2 cm x 1 cm, and 1.1

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cm x 2.1 cm light reddish" area to left wrist; "1.7 cm x 1.5 cm and 2.4 cm x 4.8 cm light reddish" area to the left forearm.

On August 9, 2018 at 2:09 PM, V1, Administrator said R1's bruises were reported by V4 (LPN) and V5 (RN) on August 4, 2018, in the afternoon. V1 said the facility determined R1's bruises were a result of R1's "historical behaviors." V1 continued to say, R1 was banging and thrashing R1's arms around and hit the wheelchair and side rails. V1 said V1 watched the facility video surveillance of R1 from dinner on August 3, 2018 until R1 went to bed and V1 saw no interactions with any other residents or times when the bruises may have occurred. V1 said V1 spoke to V16 (RN) on Sunday, August 5, 2018, and V16 said R1 was "absolutely wild." V1 said V1 asked V16 why there was no charting in R1's EMR about the incident if R1 was so wild. V1 said when R1 became agitated the CNAs should have made sure [R1] is safe, given R1 a break, and tried another staff member."

There are no progress notes entered in R1's Electronic Medical Record (EMR) from August 2, 2018 at 12:38 PM until August 6, 2018 at 1:30 PM (R1's bruises were first reported on August 4, 2018).

R1's facility Admission Record printed August 9, 2018 shows diagnoses to include: unspecified dementia with behavior disturbance; mood disorder due to known physiological condition; Parkinson's Disease; altered mental status; Alzheimer's Disease; major depressive disorder; and anxiety disorder.

R1's Minimum Data Set (MDS) dated May 28, 2018 shows R1 has a Brief Interview for Mental

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Status (BIMS) score of 10 (moderate cognitive impairment); has verbal behavioral symptoms (threatening others, screaming at others, cursing at others); it is somewhat important for R1 to choose what to wear; it is very important for R1 to take care of R1's personal belongings; requires extensive assistance of two or more staff members for bed mobility; and requires extensive assistance of one staff member for transfers, dressing and personal hygiene.

R1's Abuse/Neglect Assessment dated May 25, 2018 shows a score of 6 (high risk for abuse).

A behavior note dated August 6, 2018 shows it was reported that V14 and V15 (CNAs) were laying R1 down for the night and R1 was upset about not having R1's own nightgown. This note continues to say R1 was punching and banging R1's arms against R1's bed rails in anger. This behavior note was a late entry (not charted until 3 days after the incident).

R1's behavior care plan (last revised June 11, 2018) shows "[R1] has agitation and refusal of care at times, may become combative or verbally abusive to others related to dementia, anxiety and depression." R1's interventions include: avoid arguing, reasoning, or reacting to comment from resident; avoid rushing the resident and re-approach as needed; monitor behavior episodes and attempt to determine underlying cause; and document behavior and potential causes.

The facility's Bruise - Investigation for Individualized Interventions dated August 7, 2018 shows V14 and V15 (CNAs) were notified R1 was attempting to put R1's self to bed. V14 entered the room first and started getting R1 ready for

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S9999	Continued From page 9 bed. R1 wanted to wear one of R1's own nightgowns, but none were available. R1 became upset and yelled out, "help me, she's trying to kill me." V15 heard the yelling and entered the room. V15 opened R1's closet to show R1 there was no gown in there. R1 responded by yelling they were trying to kill R1, calling them names, and told them to go to hell. The report continues to say R1 started hitting R1's arms on R1's wheelchair. R1 attempted stand and V14 and V15 transferred R1 into bed, as R1 continued to yell and hit/kick at them. It was reported that R1 was banging R1's arms on the side rails of the bed. On August 14, 2018 V1 faxed a statement that the facility has no specific Dementia Care Policy. B	S9999		