STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002729	A. BUILDING: _____ B. WING _____	C 04/19/2018

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EDWARDSVILLE NSG & REHAB CTR	401 ST MARY DRIVE EDWARDSVILLE, IL 62025

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S 000	Initial Comments Complaint 1842394/IL101814	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal 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	S9999	Attachment A Statement of Licensure Violations	

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resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidence by:

Based on interviews and record review, the facility failed to provide a safe resident environment and protect residents from abuse for 1 of 9 residents (R2) reviewed for abuse in the sample of 9. This failure resulted in psychosocial harm in that, a reasonable person would react to such a situation with feelings of anxiety, distress, fearfulness and humiliation.

Findings include:

R2's Minimum Data Set (MDS) dated 4/10/18 documented R2 is a 78 year old female who has a Brief Interview of Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS also documents R2 requires extensive two staff assistance in mobility/toileting/dressing and requires one person physical assist with bathing.

The Admission record, dated 10/2006, documents R2's diagnoses as Vascular Dementia with behavioral disturbance, Hypertension, Convulsions and major depressive disorder.

R2's Nurse's Note dated 4/8/2018 at 8:40 AM documents, "0840 notified by housekeeper that she witnessed roughness with resident. Staff immediately removed CNA from facility and

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Administrator and DON (Director of Nurse's) notified. Attempted to notify IDPH (Illinois Department of Public Health) via fax however fax machine inoperable and emails currently not working. Administrator left two messages at IDPH office. Fax machine began working later and report sent at that time. Police notified, MD notified and POA notified and Ombudsman notified. Neuro checks initiated, and 30 min visual checks started. Upon interview with resident (R2) stated nobody has been physically or verbally abusive to (R2)."

The Facility's Final Investigation Report, undated, documents, "On 4-8-2018 at 08:38am it was witnessed by staff members that (R2) was in (R2's) wheelchair at nurse's station with (R2's) head down, when (V5, Certified Nurse's Aide/CNA) came up to (R2) and pushed (R2's) head back and then placed hand on (R2's) back of neck and stated to resident, 'Get your a** back to your room.' Staff immediately notified nurse who intervened and separated resident from (V5). (V5) was escorted out of building and investigation immediately began." The Report documented "Upon investigation, administrator interviewed all alert residents with no reports of abuse or mistreatment. Abuse allegation is substantiated and (V5) has been terminated."

Facility's documentation of phone interview on 4/8/18 at 2:00 PM with V5 documents, " Coming out of DR (dining room) no pants head down calling name lifted head up put hand on forehead shook (R2) around. I don't honestly recall cursing."

On 4/18/2018 at 9:50 AM, V4, Licensed Practical Nurse (LPN), stated "(V8, Housekeeper) reported to me on 4/8/2018 at 0830 am V8 had seen (V5,

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CNA) push (R2's) head up and pulled back of neck and stated, "Get (R2's) a** down to (R2's) room." I immediately removed her, which (V5) became argumentative with me. I had to send her home due to report of situation. (V6 Certified Nursing Assistant Coordinator) notified and she called the Administrator." V4 also stated, "I have had to educate (V5) at least twice in past for cursing."

On 4/19/2018 at 8:45 AM V8 stated, "On 4/8/2018, I let (V5) know that (R2) didn't have R2's diaper on and R2's pants was pulled down to knees. (R2) was wheeling R2's self to the dining room. R2 was in hallway near nurse's station. It's not unusual for R2 to take R2's own diaper off and not pull pants all the way up. When I told (V5), she came around nurse's station and (R2) had (R2's) head down. (V5) put the palm of her hand on (R2's) forehead forcing (R2's) head to jerk backwards as (V5) stated, 'Why the f*** don't you have a diaper on?' (R2) did not respond. (V5) then had one hand on the wheelchair and grabbed (R2) by the back of the neck and (V5) said, 'Get your a** back to your room.' (R2) did not respond. (V5) took (R2) back to (R2's) room. I went to get (V4) and told her what happened."

V8's written statement, dated 4/8/2018 documents, "On 4-8-2018, I informed (V5) that (R2) didn't have any bottoms on when (R2) was headed to the dining room for breakfast around 7:30 am.(V5) came from behind the nurse's station and approach (R2) who had (R2) head down that's when I observed (V5) push (R2's) head back and then grabbed (R2) by the back of the neck and wheeled (R2) to (R2's) room telling (R2) to get (R2's) (a**) to (R2's)room. I immediately reported to the nurse (V4) and she called the Administrator after she removed (R2)

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from the situation."

On 4/17/2018 at 10:00 AM, V9, Housekeeper, stated, "(V5) pushed (R2) head. I gave a statement, reported to the nurse and she called administrator. We have had in-services and had another meeting and they sent (V5) home."

V9's written statement, dated 4/8/2018 documents, "It was about 8:38 am I was at the nurse's station when (R2) came from the dining room and (V8) Housekeeper told (V5) that (R2) pants is right on (R2's) knees. She pushed (R2's) head back rough and told R2 to get her (a**) back to the room."

On 4/17/2018 at 6:13 PM, V13, Local City Police Officer, was interviewed. V13 stated that during V13's investigation of the incident R2 said "What she did to me wasn't right."

On 4/18/2018 at 11:40 AM ,V1 stated, "(V6) called me and I also spoke with (V4) who advised that (R2) came out room without pants on and (V5) pushed head back and turned (R2) around by (R2's) neck and guided back to room, stating "Get you're a** back in room."

On 4/18/2018 at 11:50 AM V2, Director of Nursing (DON) stated, "(V1) called me on 4/8/2018 at 8ish. I did (R2's) full assessment skin check and took R2 to bathroom and (R2) didn't complain of any pain." V2 stated V5 has been disciplined in the past for "Bad attitude".

On 4/18/2018 at 12:05 PM V3, Registered Nurse/RN stated, "I was told about it. (V4) called me, incident involving (V5) and (R2) involving abuse, pushed R2's head back. "Oh yeah (V5) curses."

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On 4/19/2018 at 9:00AM V7, R2's Power of Attorney (POA) stated prior to R2's mental decline, "(R2) would have been upset over this incident and would have been withdrawing. (R2) would have had behavioral changes."

On 4/19/2018 at 9:00 AM R2 stated, "I wouldn't like that, if someone cursed or pushed my head or grabbed my neck."

On 4/19/2018 at 1:25 PM V15, R2's Physician, stated, "I would expect staff to treat resident's like their own parents." When asked if this behavior was acceptable from staff, V15 responded "Absolutely not. I would expect staff not to handle residents roughly or curse at them."

On 4/19/2018 at 1:20 PM R4 and R5 stated if a staff member cursed at them or shook them it would make them feel angry, bad and/or frightened.

A reasonable person would react to such abuse with such feelings as agitation, anxiety, frustration, fearfulness, humiliation and punishment.

Facility's Policy and Procedure 'Abuse Prevention Program' dated December 2016 documents, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source

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S9999	Continued From page 6 ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." The Policy documents "The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident." (B)	S9999		