STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008379	A. BUILDING: _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREST NURSING PAVILION	515 NORTH MAIN SANDWICH, IL 60548

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S 000	Initial Comments Facility Reported Incident of January 31, 2018/ IL100212 Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a)	S 000		
S9999	Final Observations 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidence by:

Based on observation, interview, and record review, the facility failed to protect residents from physical and mental abuse this resulted in R1 being slapped across the face by a staff member and R2 becoming angry, swearing and attempting to stand.

This applies to 2 of 3 residents (R1, R2) reviewed for abuse in the sample of three.

The findings include:

1. R2's October 25, 2017 Minimum Data Set (MDS) showed her cognitive skills for daily decision-making were severely impaired. The MDS showed R2 needs extensive physical assistance of one person for transferring, walking and dressing.

R2's October 25, 2017 activities care plan showed R2 is only alert and oriented to herself, she enjoys observing activities, reading, and "my stuffed dog Teddy." Interventions on the care

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plan include "Offer [R2] her stuffed dog ..." and "Calm and soothe [R2] as needed ..."

R2 had other current care plans for mood problems related to anxiety, depression relating to dementia, impaired cognitive function, behavioral outbursts, and anti-psychotic and anti-anxiety medication use.

The facility's February 8, 2018 Final Incident Investigation Report for an abuse allegation concerning R2 showed two Certified Nursing Assistants (V5 and V8-CNAs), and an Activity Aid (V6) were present in the second floor back dining room when V14 (CNA) abused R2 on February 1, 2018.

On February 14, 2018 at 9:55 AM, V6 stated it was before lunch when V14 approached R2, stuck her tongue out, and made faces at her "to get her riled." V6 also described V14 as "shaking her butt at her." V6 stated she told V14 to stop because she was making R2 mad. V6 said V14 laughed. V6 stated R2 reached to grab her cup of supplement shake that was on the table and V14 reached for it too, and it spilled on the table. V6 stated V14 got a clothing protector to wipe it up, then went to the cabinet to get spray cleaner. V6 stated V14 sprayed the cleaner on the table, and then sprayed it at R2.

V6's February 5, 2018 written statement showed "I told [V14] to stop because [R2] was clearly getting mad ..." The statement continued and showed "[V14] grabbed some spray cleaner and sprayed it at [R2] hitting her arm ..."

V6 stated V8 and V5 were both present during the incident.

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On February 14, 2018 at 3:35 PM, V8 stated "I don't know why a person would do that to a resident" and added, "I would classify it as abusive."

V8's February 4, 2018 written statement showed "[V14] deliberately took measures to attempt to anger [R2]-she blew in her face and pulled on her stuffed dog ..." The statement continued " ...her success in getting a rise out of " [R2] "made her [14] smile and laugh ..."

On February 14, 2018 at 2:30 PM, V5 stated V14 "stuck her tongue out (at R2) ... everyone knows that gets R2 upset ..." V5 added V14 "squirted the table (with the chemical cleaner) and squirted [R2] to get her more upset and [R2] started to stand up ..."

V5's February 6, 2018 written statement showed V14 "started messing with [R2] and how you start to get [R2] upset is if you stick your tongue out at R2 which was the first thing [V14] did to upset [R2] ..." The statement continued V14 "went and got a clothing protector and the green bottle of some type cleaning liquid and sprayed it [R2] more than three times ..."

The chemical sprayed at R2 showed a Hazardous Materials Identification System "Health" rating of 3, indicating the chemical is a "serious hazard." On February 15, 2018 at 1:35 PM, V15 (Housekeeping and Laundry Supervisor) stated she would not want that sprayed on a resident because it is not safe for them.

On February 15, 2018 at 1:10 PM, V2 (Director of Nursing) stated the review of the surveillance tape showed V14 bent over in front of R2, moved her bottom up and down, and put her own hand

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on her bottom, shaking it at R2. V14 also took R2's stuffed dog away from her, and waved it up back and forth over R2's head, out of her reach. R2 tried unsuccessfully to reach for it. V2 stated R2 looked so mad she tried to stand up. V2 stated when V14 finally walked away from the table where R2 was sitting with her back against a wall, V14 used her body to shove the table in farther toward where R2 was sitting.

In the policy statement of the facility's Abuse Prevention Program (revised November 2013), it showed "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion."

The facility's November 2013 Reporting Abuse to Facility Management policy defined abuse as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." The policy further defines mental abuse as " ...humiliation, harassment, threats of punishment, or withholding of treatment or services."

2. On February 14, 2018 at 11:26 AM, R1 was sitting in her wheelchair reading a book.

R1's MDS (Minimum Data Set) dated December 21, 2017 showed R1 is cognitively intact, requires extensive assistance of two persons for transfers, and requires extensive assistance of one person for dressing. The same MDS showed it is "very important" to R1 to choose her own bedtime while in the facility. On February 15, 2018 at 9:47 AM, V12 CNA (Certified Nurse Assistant) said R1 prefers to go to bed around 9:30 PM.

On February 14, 2018 at 11:26 AM, R1 said that

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on the evening of January 31, 2018 between the hours of 7:00 PM and 8:30 PM, V13 (CNA) was yelling at me to go to bed. "I told her I didn't want to go to bed. I told V13 no and she slapped me across the face." R1 added, "It made me feel sad." R1's posture became slumped in the wheelchair and she avoided eye contact during her description of the incident.

On February 14, 2018 at 7:50 AM, V2 DON (RN, Director of Nursing) stated during her investigation she determined that between the hours of 7:00 PM and 8:30 PM on January 31, 2018, V13 CNA went into R1's room three times and told her it was time to go to bed. V2 reported that R1 told V13, "no it's too early" each time. V2 stated that the third time V13 went in, V13 closed the door and told R1 to go to the bathroom. V2 said that R1 told V13 "no" again. V2 stated V13 said, "Yes you are," and R1 said, "no I'm not." V2 added R1 shook her fist at V13, and said, "I don't want to go to bed."

V2 stated V13 then slapped R1 across the face.

On February 14, 2018 at 9:30 AM, R7 (R1's former roommate) stated she heard V13 CNA and R1 arguing in loud voices about R1 going to bed on the evening of January 31, 2018.

On February 15, 2018 at 10:08 AM, V11 CNA said, "It is absolutely not okay to slap a resident!" V11 added, "That is physical abuse and it's wrong."

When asked why she believed what R1 reported to her about being slapped by a staff member, V2 DON stated R1 is alert and orient and she never changed her story throughout the investigation. V2 continued to say R1 has lived here a long time

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S9999	Continued From page 6 and has never complained about anyone. (B)	S9999		