STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

(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 Statement of Licensure Violation: 1 of 1 Violation 300.1210b)4) 300.1210d)3) 300.3240a) 300.3240e) 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 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: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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)

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)

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These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to ensure residents were free from verbal and/or physical abuse for 3 of 4 residents (R23, R81 and R100) reviewed for abuse in the sample of 32. This failure resulted in psychosocial harm for R23 in that, a reasonable person would react to such a situatuion with feelings of anxiety, distress, frustration and fear.

Findings include:

1. R23's Physician Order Sheet dated 05/01/18 documents R23 has diagnoses of Depression, Arthritis, and Alzheimer's.

R23's Minimum Data Set (MDS) dated 11/14/17 documents R23's Brief Interview of Menal Status (BIMS) score was a 3, which represents severe impairments for decision making.

R23's Care Plan dated 07/2018 documents "I have a diagnosis of dementia. I also have lung cancer that was treated with radiation, and the brain was also treated with radiation for prevention. I am unable to follow instructions, and I don't communicate well. R23's Care Plan also documents approach me from the front in an unhurried manner. I require assistance with my Activities of daily living due to Alzheimer's.

R23's Incident Report Form dated 08/15/17 documents an allegation of abuse was received.

V13's Witness Statement from the Facility

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Incident Report Form dated 08/15/17 documents V13 Housekeeper stated "Around 1:50 PM I was called down the hall by (V14 Certified Nursing Assistant/CNA) to help her with (R23). (R23) cannot speak or feed herself. (V14) got upset with the resident, because she wet the bed. (V14) was trying to rush and change (R23). (V14) stated she was tired of her F------g A- -. She was also calling (R23) b- - - -h. (V14) was pushing and shoving (R23) around in the bed and cursing. (V14) left (R23's) clothing half way down. (V14) slapped her with a glove 'mess' (bowel movement) on it."

The facility's untitled letter dated 08/17/17 documents on 08/15/17 at approximately 2:00 PM V13 reported V14 for using profanity and wiping R23's face with a soiled glove. V14 was suspended pending the outcome of the investigation. The letter also documents that R23's medical doctor, Illinois Department of Public health, and Resident Representative were all notified. The untitled letter further documents that V14 did admit that ,while she was providing care, she stated to V13 "she sh-t on my arm." V14 was terminated for inappropriate communication, while providing care.

On 5/16/18 at 2:00 PM, V1, Administrator, confirmed V14 was terminated due to the abuse allegation.

2. R100's Physician Order Sheets (POS) documented R100 had a diagnosis in part, of dementia, diabetes, nausea, schizophrenia, pain, hypothyroidism, coronary artery disease, and constipation.

R100's Minimum Data Set (MDS), dated 10/01/2016 ,documents in part, R100 has a Brief

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S9999	Continued From page 4 Interview for Mental Status (BIMS) score of 8 out of 15 (moderate impairment). On 05/16/2018 at 3:30 PM, V1, Administrator stated "(V10) was terminated for an incident with (R100). I believe she was fired." A written statement from V10, Certified Nursing Assistant, (CNA) dated 08/21/2017 stated "(R100) called out at 4:15 AM 'ish' to watch the game I told him it was not on, his roommate then got up to turn the television on and (R100) kept yelling he wanted to watch the game. I told him the game was not on and let him know what time it was on, he acted like he could not hear me. I got closer and told him the game was not on and to stop yelling so his roommate can sleep that is when he pulled my hair I asked him to let go and he would not while trying to pull away he turned out of his bed to kick me so smacked his hand away from my hair then reported the incident to the nurse on duty." A written statement from V11, Licensed Practical Nurse (LPN), dated 8/21/2017 documented, "I was at the nurses' station and heard resident yelling out 'turn the ball game on' several times, then (V10) came to me and said somebody need to call his son, I asked why what happened, and the CNA said she was trying to tell the resident that there wasn't any ball game on and the resident said he couldn't hear her and when she got closer to resident's ear he pulled her hair and she hit his hand away and then the resident tried to kick her. At this time the call light was on so I went to answer call light. I ask the resident what is it that he needs and he stated he spilled water on the bed and needs linen changed. I then told resident it would be a minute, everybody is busy and I then asked did he pull the CNA's hair and	S9999		

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he stated "No, I didn't pull her hair and she hit me right here pointing to left side of face and right here pointing to right wrist, then asked is it red. No redness to face but the right wrist had some redness. I then told CNA to come off floor and clock out. This was 4:30 AM."

The Facility Report dated 08/23/2017 documents in part, "On 08/21/2017 at 4:30 AM, (R100) reported to his nurse that his CNA, (V10), struck him on the left side of his face and right wrist. (V10) was immediately suspended pending the outcome of the investigation. Charge nurse assessed (R100) for injury; Pain/Skin Evaluation were completed with redness to the right wrist noted/ (R100) denies pain. Physician Resident Rights and State were made aware of the incident. An investigation was initiated."

The Category One Violation Employee Corrective Counseling Memorandum documents "Category One Violation as 'Termination of Employment' for (V10) on 08/25/2018. On 08/21/2017 at approximately 4:30 AM (R100) reported to his nurse that his CNA (V10) struck him on the left side of his face and right wrist. (V10) was immediately suspended pending the outcome of the investigation. Charge nurse assessed (R100) for injury: Pain/Skin Evaluations were completed with redness to the right wrist noted. (R100) denied pain. Physician, Resident Representative were made aware of the incident. Conclusion is listed on separate document dated 08/23/2017. Category 1.13- Conduct is immoral, improper, fraudulent or inappropriate in the workplace."

3. R81's POS dated May 2018, documents R81 has a diagnosis in part, of morbid obesity, pulmonary hypertension, hypothyroidism and atrial fibrillation. R81's MDS dated 03/26/2018

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S9999	Continued From page 6 documents a BIMS score of 15 out of 15 (cognitively intact). On 05/16/2018 at 9:36 AM R81 stated, "I am a large woman and I had diarrhea and (V16) Certified Nursing Assistant (CNA), she wiped me but she only did the outside. I told her to dig in there and get that stuff out and she acted like I was bothering her. My private area was burning and it needed cleaned. When I asked the (V16) she told me I was a pervert. I told (V1, Administrator) about it and she asked me if this was a nursing issue or if I felt I was verbally abused? I told her I feel emotionally and verbally abused and I do not want that CNA to ever give me care again. Then about a week later (V1) came back to me and asked me again if I felt like I was verbally abused or just an issue with care not being given correctly and I responded "whatever" as we had already discussed this and I felt awkward and like she just was going to do whatever she wanted to do." I again said "Please don't let that CNA take care of me ever again." On 05/16/18 at 11:13 AM, V1 stated "I did not suspend (V16) the CNA because after talking with the resident she stated it was not abuse." The Facility Incident Report dated 05/11/2018 documents in part, "Resident reported that her CNA on evening shift yelled at her during care on 05/10/2018. Patient reported this allegation talked to (V1) at approximately 12:30 PM. V16's Individual Employee Time Card dated 05/10/2018 documents V16 worked 3:51 PM to 10:01 PM. On 05/11/2018 V16 worked 5:43 PM to 5:56 AM. The timecard does not documentV16 was suspended pending the investigation.	S9999		

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S9999	Continued From page 7 The Facility Incident Report dated 05/11/2018 documents "Resident reported that her CNA on evening shift yelled at her during care on 05/10/2018. Patient reported this allegation talked to Executive Director at approximately 12:30 PM." R81's statement dated 05/11/2018 documents, "(V16), yelled at me because I wanted her clean me up again." V1, Executive Director, "What did they say?", "I don't know what she said but I didn't like it. She was talking to (V18, CNA)." (B)	S9999		