Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008346	A. BUILDING: ____ B. WING ____	C 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINE CARE NURSING & REHAB	120 SOUTH LAND STREET HARRISBURG, IL 62946

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S 000	Initial Comments Facility Reported Incident Investigation of 6/29/2021/ IL135633	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690b) 300.1210b) 300.1210d)6) 300.3240a) 300.3240b) 300.3240d) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

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:

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.

Section 300.3240 Abuse and Neglect

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

b) A facility employee or agent who becomes

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aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

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)

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)

These Regulations were not met as evidenced by:

Based on interview, observation and record review, the facility failed to ensure residents were free from abuse for 1 (R1) resident reviewed for abuse. This failure resulted in R1 being slapped in the face and having a blanket pushed into R1's mouth by V4. This resulted in swelling, bruising and a small laceration of R1's upper lip.

Findings Include:

1. R1's facility record Face Sheet documents R1 as being 74 years of age with diagnoses that include Paranoid Schizophrenia, Alzheimer's Disease and Anxiety. R1's Quarterly resident assessment dated 4-21-2021, Section C, Cognitive Assessment documents R1 with a

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BIMS (Brief Interview for Mental Status) score of 12 out of 15 indicating moderate cognitive impairment.

According to V10's written statement dated 6-30-2021, on the morning of 6-29-2021, V10 and V12, both CNA's, went into R1's room around lunch and noted swelling to R1's upper lip. On 7-9-2021 at 12:50 PM, V10 stated this was immediately reported to V9, (Licensed Practical Nurse.) V9's undated written statement documents V9 assessed R1 and noted R1's top lip looked swollen and with further assessment, V9 observed a small v shaped cut on the inside of her R1's top lip. V9 further documented in her statement that at this time, R1 told V9, with V10 and V12 present, that the lady with the big hips had done it the day before. On 7-13-2021 at 11:20 AM, V9 stated that R1's story kept changing on when it had happened and what exactly had happened and she assumed R1 had bit her lip and did not report it as an allegation of abuse.

According to V7's (RN) 6-29-2021 written statement, At 9:00 PM on 6-29-2021, V7 was assessing R1 after being told by staff that R1 had a swollen lip and noted R1's upper lip as large and puffy with some dried blood noted on both upper and lower lips. V7 further documented that R1 told her " I know you may not believe this but the girl with the wide hips, that was wearing a red and black vest smacked me in the mouth and told me to shut up. She then stuffed a piece of clothing or maybe a blanket into my mouth". V7 documented R1 told V7 that it had happened when she was being put back to bed after a meal. On 7-9-2021 at 9:55 AM, V7 verified that the statement she had written and signed was accurate. V7 further stated she had immediately

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notified V6, the on call Registered Nurse, of the abuse allegation.

On 7-9-2021 at 8:40 AM, V1, Facility Owner/Licensed Nursing Home Administrator stated he became aware of an allegation of abuse made by R1, when he received a call on the evening of 6-29-2021 from V6 RN ADON, telling him that V7 had contacted V6 and reported that R1 had made an allegation of abuse by staff to V7. V6 then contacted V8, Director of Nursing and V1 and reported the allegation. V1 stated police were notified immediately and an investigation was immediately initiated. V1 further stated that thru the investigation, it was determined that V4 CNA was who R1 was alleging had slapped her then shoved something in her mouth. V1 stated V4 was not present in the building at the time he became aware of the alleged abuse but was scheduled for work the following morning. V1 stated, V4 was not allowed on the floor the following morning 6-30-2021 and the investigation continued with V4 being brought in for a statement. V1 stated V4 told him that on 6-29-2021, after breakfast V4, had gone in to put R1 to bed and R1 had accused her of hitting her but denied any interaction with R1. V1 stated V4 was asked if anyone else was present and V4 stated that V5, CNA was in the room at the time R1 had accused her of slapping her. V1 stated police were called to the facility after V4's statement was obtained and a statement was also obtained from V5. V1 stated that V5 admitted, with the police present, she had witnessed V4 slap R1 and roll a blanket up and put it in R1's mouth. V1 stated V4 was arrested at this time and removed from the building by police.

On 7-9-2021 at 1:00 PM, V5 stated that V4 had gone into R1's room sometime right after

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S9999	Continued From page 5 breakfast on 6-29-2021 because R1 was yelling loudly, and V5 had followed V4 into R1's room. V5 said V4 was talking to R1 at which time she observed V5 slap R1 in the face and put a blanket in R1's mouth. V5 admitted she did not report the abuse at that time. On 7-9-2021 at 1:55 PM, R1 was observed in her room in her bed. R1 was asked about an incident in which she had reported that someone who worked here had hit her and put something in her mouth. R1 sighed and looked away and stated that she really did not want to discuss it, that she "wanted it to all just wash away". She then stated "she is in jail now and she does not work here anymore." I asked her if she felt safe here and if she felt the staff here were trying to keep her safe and she replied yes. I asked if she could tell me if anyone else was in the room when this event had occurred and she stated "honey, I don't know, I just want to forget it". I observed a small area of fading bruising above her upper lip at this time. When asked about the bruising, R1 stated it had happened when the woman had shoved something in her mouth. V13 Medical Doctor examined R1 at the facility on 6-30-2021 and documented in a Physician Progress note dated 6-30-2021 "Patient and staff states last noc (night) CNA (who has been arrested by police this am) became angry with patient and slapped her in face and forcebily stuck a towel in her mouth, Exam shows localized swelling around mouth, upper and lower lips. No bleeding lesions at this time but areas of abrasion noted on mucosal surfaces of lips. No other bruising, skin lesions noted on patient's body. Denies pain anywhere but around lips.	S9999		

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S9999	Continued From page 6 Because the witnessed abuse of R1 and R1's allegation of abuse was not reported immediately to the Administrator, V4 remained in the building and on duty providing resident care for the remainder of V4's shift which allowed for the potential for contact with all 43 residents of Side 2 of the facility. This was verified by V8. A 6-29-2021 'Punch Summary Report' verified V4 clocked in at 5:47 AM and clocked out at 2:01 PM on 6-29-2021. On 7-9-2021 at 8:40 AM, V1, Owner and Licensed Nursing Home Administrator, verified that the allegation of staff to resident abuse of R1 was not reported to the State Survey Agency until later, on the evening of 6-29-2021, after he was made aware of the allegation. The facility Abuse Prevention Policy and Procedures dated 8-16-2019 documents, "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...Employees are required to report any incident, allegation or suspicion of crime or potential abuse, neglect or misappropriation of property they observe, hear about, or suspect to the administrator...Supervisors shall immediately inform the administrator or in the absence of the administrator, the person in charge of the facility, of all reports of incidents, allegations or suspicions of potential abuse, neglect or misappropriation of property." Under Section V. Protection of Residents, the facility Abuse Prevention Policy and Procedures documents "Employees of the facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact	S9999		

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S9999	Continued From page 7 immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible abuse... shall not complete the shift and will be suspended pending the outcome of the investigation". (A)	S9999		