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	IL6003560	A. BUILDING: _____ B. WING _____	C 07/03/2024

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GOLDWATER CARE GIBSON CITY	620 EAST FIRST STREET GIBSON CITY, IL 60936

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S 000	Initial Comments Facility Reported Incident of 6/22/24/IL175028	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240g) 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 a) Comprehensive Resident Care Plan. A	S9999		

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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.

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

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c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

d) 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)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure the residents' right to be free from mental and physical abuse by staff. R2 experienced physical pain and psychosocial harm including fear, feeling unsafe, crying and mental stress/worrying. R3 experienced mental abuse through crying, being upset and scared. These failures affect two (R2, R3) residents out of four residents reviewed for abuse in a sample list of eleven residents.

Findings include:

The facility undated policy titled 'Abuse, Neglect and Misappropriation of Resident Property'

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documents Physical/mental-the facilities policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all state and federal regulations. Residents must not be subject to abuse by anyone including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the residents, family members or legal guardians, friends or other individuals. Abuse definition is documented as the willful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families. Examples of verbal abuse include but are not limited to threats of harm and saying things to frighten a resident. Physical abuse is defined as hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Mental abuse is defined as humiliation, harassment, and/or threats of punishment or deprivation. Involuntary seclusion is defined as the separation of a resident from other residents, from his or her room, or confinement to his or her room with or without roommates against the residents will or the will of the resident representative.

1.) R3's Initial Report to the State Agency dated 7/1/24 documents R3 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her.

R3's undated Abuse Investigation Form documents V1 Administrator was notified on

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6/29/24 at 10:20 AM that R3 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her. This report documents "(R3) stated that the agency staff (V13, V14) had argued with her about how to do her care, did not get her up with a sit to stand to the bedside commode, but attempted to roll her over and clean her. This caused her pain in her leg and she wet which caused the agency staff to raise their voices, throw things on the floor and leave the room leaving her in the bed uncovered."

On 6/30/24 at 9:45 AM, R3 stated "Yesterday (6/29/24) two agency Certified Nurse Aides (CNA) (V13, V14) came into my room a little after 5:00 AM Saturday (6/29/24) morning to get me up for breakfast. I had asked to use the lift (partial mechanical body lift) to get me up to the commode. They (V13, V14) said they weren't going to get me up to the commode and were just going to change me in my bed. They (V13, V14) were rolling me around in bed so hard. I told (V13, V14) that my left leg hurt. I have been in the hospital twice this month for the awful pain in my left leg. They (V13, V14) grabbed my left leg and twisted my left leg and so I let out a yell. I told (V13, V14) several times to quit twisting my left leg but they just kept on. Then they (V13, V14) just left me there laying in a wet bed half dressed. I told (V16) how awful those two (V13, V14) were. I am afraid that they (V13, V14) will come back and hurt me worse."

On 6/30/24 at 12:50 PM, V16 Registered Nurse (RN) stated V16 talked with R3 about 5:30 AM. V16 RN stated "(R3) was crying so hard she had trouble even talking. I tried to console (R3) but she was crying so hard she was inconsolable.

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(R3) told me that (V13, V14) CNA's were 'very rough' with her that morning. (R3) had asked to use the bathroom and she was told no. (R3) stated (V13, V14) rolled her around so hard and rough that she had urinated in her bed because she was scared of them."

On 6/30/24 at 12:30 PM, V15 Social Service Director (SSD) stated R7 (R3's roommate) reported to V15 SSD "Those two Certified Nurse Aides (CNA's) (V13, V14) were mean to my roommate (R3) this morning. I heard them yelling and carrying on. They (V13, V14) just threw her blankets on the floor and walked out." V15 SSD stated R3 was still upset and crying throughout the entire conversation.

On 6/30/24 at 1:40 PM, V7 Restorative Certified Nurse Aide (CNA) stated "When I entered (R3's) room, she was crying. (R3) had her pants around her knees, her shirt was tucked up under her breasts, her bed was wet and she didn't have any covers on. This would have been about 5:40 AM or so. (R3) said her left leg hurt. I had to help (R3) move her left leg because it was hurting her so bad. Normally (R3) can move her own legs, slowly, but she can do it on her own. Yesterday (6/29/24) (R3) couldn't even move her left leg on her own due to the pain."

On 7/1/24 at 10:05 AM, V17 Licensed Practical Nurse (LPN) stated the morning of 6/29/24 was very chaotic. V17 LPN stated R3 had reported to V16 Registered Nurse (RN) that they (V13, V14) scared her and hurt her leg. V17 LPN stated R3 has been hospitalized twice in June for left leg pain but the Physicians are not able to find a cause of the pain. V17 LPN stated "It ended up that (R3) alleged physical abuse and (R2) alleged mental abuse both by (V13 and V14) CNA's. V17

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LPN stated "I went to (R2's) room first about 6:30 AM. (R3) told me that 'those two (V13, V14) were awful, mean to her and hurt her leg'. V17 stated R3 said 'They (V13, V14) scared me so bad I peed as they were wiping me and (V13) Agency CNA yelled out. V17 stated R3 reported that V13 and V14 Agency CNA's left her in the wet bed half dressed and crying. V17 LPN stated "When I saw (R3), she was crying hysterically. It took her a long time to be able to calm down enough to talk to me and tell me what happened."

2.) R2's Initial Report to the State Agency dated 7/1/24 documents R2 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her.

R2's undated Abuse Investigation Form documents V1 Administrator was notified on 6/29/24 at 10:20 AM that R2 had complained that V13 and V14 Agency Certified Nurse Aides (CNA) were rude to her and not listening to her when she told them how to take care of her.

On 6/30/24 at 10:10 AM, R2 stated "There were two agency CNA's (V13, V14) that were here (facility) yesterday (6/29/24). (V13) Agency CNA pushed a washcloth in my hand and told me to wash my face. I can't do that because of my Arthritis." (R2's hands appear deformed at knuckles. R2 was unable to open both hands completely.) R2 stated "(V13) kept pushing the washcloth into my hand. It hurt a bit. I told them (V13 and V14) multiple times that I just can't physically do it. I showed (V13, V14) my hands so they could see how bad they are. I pushed the washcloth back at (V13). I don't deserve that. They (V13, V14) just rolled their eyes and looked at me so mean. I have to say I was scared that

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morning." R2 stated later that morning after breakfast V13 and V14 agency CNA's assisted R2 from her wheelchair to her bed. R2 stated "They (V13, V14) threw me into bed. (V14) CNA grabbed my hand (R2 holding onto her own Right hand) and squeezed so hard it really hurt. It didn't bruise but it sure hurt. I yelled out several times and they (V13, V14) left me laying there in my bed."

On 7/1/24 at 10:08 AM, V17 LPN stated "I could hear (R2) yelling from her room with her door closed four doors down in the dayroom on West hall. (V16) and I went to investigate. I didn't see (V13, V14) actually do anything to (R2) but I do know they had just been in there laying (R2) down after breakfast. (R2) told me that they (V13, V14) were just in her room and laid her down. (R2) told me 'I'm just so scared of them (V13, V14). Please don't let them back in my room'."

On 7/1/24 at 11:15 AM, V13 Agency Certified Nurse Aide (CNA) stated "(R2) is rude to the staff. We (staff) don't have to tolerate that. I am not helping anyone that treats me like that. (R2) was all kinds of frustrated at me and (V14) Agency CNA. (R3) was the same way. (R3) wanted to get up but she had already been incontinent so there is no reason to get somebody up after they have already been incontinent. (R3) just kept crying and wouldn't be quiet about it. There is no reason for (R3) to be crying like that. We (V13, V14) just walked out of (R3's) room."

On 7/1/24 at 2:00 PM, V1 Administrator stated "Our facility has a lot of great staff who are caring and knowledgeable to care for our residents. Unfortunately, these two Agency CNA's (V13, V14) did upset our residents R2 and R3 a great

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S9999	Continued From page 8 deal." V1 stated R2 reported physical and mental abuse to our staff and R3 reported an allegation of what could be mental abuse by (V13, V14). V1 confirmed R2 and R3 were both physically and mentally abused by V13, V14 Agency CNA's. V1 Administrator stated "We (facility) take this very seriously. My staff has already been educated. Our residents have been interviewed and say they feel safe here now. You can be sure those two Agency CNA's will not return to our facility." (B)	S9999		