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	IL6003172	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	701 SHADWELL AVENUE FLORA, IL 62839

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S 000	Initial Comments Complaint Post Visit (C/PV) to survey of 4/22/2015.	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.690a) 300.1210b) 300.3240a) 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. 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A	S9999	Attachment A Statement of Licensure Violations	

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descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that 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.

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)

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)

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The Flora Gardens Care Center failed to follow their plan of correction for the survey of 4/22/15.

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on interview, observation and record review, the facility failed to follow the facility policies and procedures of the Abuse Prevention Program to prevent episodes of staff to resident abuse, to document the incident, provide the necessary resident care and protection and failed in following the step by step Resident Protection Investigation Procedures for 1 of 1 resident (R1) from the sample of 3.

Findings include:

1. E5 (Housekeeping Supervisor and Certified Nurse Aide) was interviewed at 11:12 am on 7/28/15. When asked if she had ever witnessed abuse, E5 said " yes. " E5 said on 7/24/15 at approximately 4:30am she assisted E3 (Certified Nursing Aide) transfer R1 from bed. E5 said R1 was being resistive to care and E3 " thumped " him in the forehead and said, " I like to thump old people. " E5 said R1 threw his hands in the air, shook his head and said, " Oh ." E5 said she thought this action was inappropriate so she reported it to E9 (Registered Nurse) at approximately 6:30am. E5 said E9 told her to " write it up " and turn it in to administration. E5 said she reported to E2 (Director of Nurses), the incident and turned in her documentation when E2 arrived at work later that morning on 7/24/15. E5 said E2 called her at home later that afternoon when she (E5) was off work and asked her (E5) what she thought E3's punishment should be.

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During this interview with E5, E5 demonstrated the thumping action used by E3 as: holding the middle finger to the thumb and flicking the middle finger away from the thumb with force.

2. On 7/28/15 at 12:15pm, E7 (Registered Nurse) said, on 7/24/15 in the morning, E5 told her she was assisting E3 with R1. E5 said R1 was resistive to care so E3 " thumped " his forehead and E3 made the statement she liked to be mean to old people.

3. On 7/28/15 at 3:00pm, E9 (Registered Nurse) said on 7/24/15, E5 told her she (E5) witnessed " abuse. " E9 said E5 told her she witnessed E3 flick R1 on the forehead and make the comment she loved to torture old people. E9 said she told E5 to write up and report what she had witnessed. E9 said E5 said she was afraid she would be terminated if she reported abuse to the administrator. E9 said E5 was "beside herself" and "upset" because E5 considered this incident as abuse.

4. On 7/28/15 at 10:39am, E3 (Certified Nurse Aide) was interviewed and said the definition of abuse is " mistreating a resident in all aspects like verbally and physically." E3 said she has never witnessed abuse or been accused of abuse. When asked if thumping a resident was abuse E3 said yes, thumping a resident is abuse.

5. On 7/28/15 at 11:30am, E2 (Director of Nurses) said she has never had episodes of abuse reported to her. When asked by surveyor if any incident was reported on 7/24/15, E2 said " No." This surveyor repeated the question and E2 said E5 did write out a report and turn it in to her on 7/24/15 after 1:00pm. E2 said, E5 told her she didn't know if she should report the incident

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because she didn't want fired.

E2 said she discussed the incident with E1 (Administrator) and someone from the facility corporation (E2 could not remember who she spoke with) and they decided the incident was not abuse. E2 said E3 had not been interviewed about the incident. E2 said E3 has worked in the facility after the incident on 7/24/15 and 7/28/15. E2 said E3 will receive a " write up for inappropriate behavior."

6. On 7/28/15 at 1:10pm, E1 (Administrator) was interviewed. E1 said E2 notified her on 7/24/15 of E5 reporting an incident. The incident was of E3 flicking a resident on the head during care. E1 said E5 documented the incident on an Incident Form. E1 said E2 talked to E5 about the incident. E1 said no other forms were completed. E1 said the accused employee E3, was not questioned about the accusation until the afternoon of 7/28/15. The interview of E3 did not occur until after this surveyor questioned E2 about the incident. E1 stated when E3 was spoken to she could not remember the incident. When asked about following the facility abuse policy E1 said she did not follow the policy because she did not feel the accusation was abuse and she did not feel it was necessary to investigate any further than the one document that E5 had completed. E1 stated, " There is no indication that abuse happened."

7. On 7/28/15 and 7/30/15 observations were made randomly throughout the day of E3 performing resident care.

8. The Incident Investigation Form written by E5 and dated 7/24/15 with the time 4:30am documents; " E3 and E5 was going in to the residents room to help get him up he was fight the CNA (Certified Nurse Aide) she flipped in the

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head twice." E2 documented on this same form that she spoke with E5 at 2:05pm by telephone. E2 documented she asked E5 if she felt disciplinary action was appropriate or an abuse allegation investigation. E2 documented E5 said disciplinary action would be appropriate. E2 was questioned on 7/28/15 at 1:10pm about allowing the housekeeping supervisor to determine what type of discipline a nursing staff member should receive and E2 indicated she allows the person reporting to determine if it was abuse or not.

9. Review of a form titled, Job In Jeopardy, prepared by E2 for E3 and dated 7/24/15 was not signed by E3. It documents E3's " work performance not up to established standards." The effect is documented as " may be viewed or percepted as a willful intent for harm " and it is documented that E3 is expected to " address residents in a respectful manner. When residents are combative need to approach differently or have another staff member take over."

10. The untitled employee schedule with the dates July 1st through July 31st documented E3 was scheduled to work on the date of the incident (7/24/15) and the dates of survey (7/28/15 and 7/30/15).

11. On 7/28/15 at 3:35pm, R1 was observed and did not have any knot or bruising on the forehead.

R1's Minimum Data Set dated 3/17/15 documents R1 with impaired cognition and was unable to perform Brief Interview for Mental Status to indicate the level he is cognitively impaired. R1's assessment further states R1 needs staff assistance with all Activities of Daily Living, is an amputee and must be transferred with a mechanical lift.

12. R1's medical chart was reviewed on 7/28/15, there was no documentation about the accusation of R1 being " thumped " or " flicked " on the

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head. There was no physical assessment documented of R1's condition after the allegation . The last note documented in R1's Nurse Notes was on 5/15/15.
13. R1's Behavior Tracking sheets for July 2015 were reviewed and there was no documentation for 7/24/15.
14. The Facility Policy for the Abuse Prevention Program has a revised date of 11/11/11. Page one of this policy documents, this facility prohibits mistreatment, neglect or abuse of it's residents. It documents this will be done by, "Immediately protecting residents involved in identified reports of possible abuse" and "Implementing systems to investigate all reports and allegations of mistreatment, neglect, abuse of residents and misappropriation of property: promptly and aggressively and making the necessary changes to prevent future occurrences."
Page one of the Abuse Prevention Program policy defines abuse as, "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."
Page five of the abuse policy documents, "Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator" and "Upon learning of the report, the administrator or designee shall initiate an investigation."
The abuse policy documents, "Such reports will be made without fear of retaliation."
Page five of the abuse policy documents, "Employees of this facility who have been

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S9999	Continued From page 7 accused of mistreatment, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents." The abuse policy documents on page twelve, "If there is NOT a reasonable cause based on the current facts to suspect willful hitting, slapping, pinching, kicking or corporal punishment proceed directly to step 7, (External Reporting of Potential Abuse) Final Incident Investigation Report with reasons abuse is not suspected. If it is determined that the allegation was because of accidental improper handling, refer the employee for supervisory counseling on the proper care delivery techniques." Page eleven documents Step 7. Final Investigation Report. This documents, "The summary, conclusions, and results of the investigation will be recorded on a final written incident report" and "A summary of incident investigations involving resident harm and possible mistreatment of resident will also be sent to the facility Quality Assurance committee." "B" VIOLATION	S9999		