STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001838	A. BUILDING: _____ B. WING _____	C 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYBERG, THE	625 EAST MONROE STREET CUBA, IL 61427

(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
S 000	Initial Comments Complaint Investigation 1620841/IL83398 Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect 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 record review and interview, the facility failed to ensure that one resident (R1) was free from verbal abuse for one of three allegations of abuse reviewed. This failure resulted in R1 being verbally abused by E1 (Administrator), and R1 being fearful of E1. Findings include: The facility policy, titled "Abuse Prevention, Identification and Reporting Program Policy and Procedure (dated 3/06/14)", documents "Verbal Abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...The facility makes every effort to provide a resident sensitive and secure environment." A Minimum Data Set, dated 1/12/16, documents	S9999		

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S9999	Continued From page 2 R1 as having a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicative of R1 being cognitively intact, and without behavioral issues or memory loss. On 2/17/16 at 10:10 a.m., R1 stated E1 (Administrator) had recently "yelled" at her when she had questioned some charges from the beauty shop that were listed in her Resident Trust Account. R1 stated E1 "yelled" at her and "that wasn't right." R1 stated she was "scared" when E1 yelled at her, and is "still scared of (E1)." On 2/18/16 at 10:10 a.m., R1 was further questioned about the incident with E1. R1 still was unable to recall the exact date of the incident, but stated "(E1) yelled at me when I asked about the money and "it was hurtful...she spoke to me so rough. (E1) can be hard on us. I don't like (E1) to talk to me or anyone in that tone of voice. If she (E1) is going to speak to me that way, she shouldn't do that job." R1 stated she "certainly" felt the way E1 spoke to her was abusive. On 2/17/16 at 10:20 a.m., E3 (Licensed Practical Nurse) stated several days prior, she and Z2 (visitor) and E4 (Registered Nurse) were at the Nurses Station and they observed R1 propel her wheelchair into the Administrators office. E3 stated she heard E1 yelling at R1, "You're just here to argue about money, aren't you (R1)? I told you very clearly that (E6 - Social Services) will be back tomorrow and that's who you need to talk to. But, no. You want to sit in here and argue with me, don't you?" E3 stated "R1 came out of E1's office crying and gasping and upset." E3 stated she immediately reported the incident to E2 (Director of Nursing). E3 stated "staff are afraid" of E1. E3 stated she believes E1 verbally abused R1.	S9999		

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S9999	Continued From page 3 On 2/17/16 at 1:15 p.m., E4 (Registered Nurse) stated, on what she believed to be 2/08/15, she overheard from the Nurses Station E1 "talking sternly" to R1. E4 stated E1 repeatedly said to R1, "Are you really wanting to argue with me about this (R1)?" E4 stated R1 left E1's office crying and E3 consoled R1. E4 stated, "If someone talked to me like that, I'd be visibly shaken. No one should be spoken to like that." On 2/17/16 at 12:40 p.m., Z2 (visitor) stated she was in the facility visiting her family member the week prior. Z2 stated she overheard E1 "talking loudly" to R1, "Are you going to sit here and argue with me today?" Z2 stated, "I was in awe, because it was so loud. It was an uncomfortable situation. It sounded bad." Z2 described E1's tone as "mean." Z1 stated R1 was crying about the incident afterwards at the Nurses Station. Z2 stated she observed E3 and E2 comforting R1 immediately after the incident occurred. On 2/23/15 at 9:50 a.m., the distance from the Nurses Station to the Administrator's office was measured. The doorway to Administrator's office is located 11 feet insided the Social Services office, just off the main hallway. The door to the Administrator's office is approximately 52 feet from the Nurses Station. (B)	S9999		