STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009864	A. BUILDING: _____ B. WING _____	C 03/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY VILLAGE	1200 EAST GRANT STREET MACOMB, IL 61455

(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 Violations: 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 agent of a facility shall not abuse or neglect a resident. (A, B) (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 facility administrator. (Section 3-610 of the Act) 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. (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 Requirements are not met as evidenced by: Based on record review and interview, the facility failed to protect a resident (R2) from repeated verbal and physical abuse by a staff member,and the facility neglected to immediately remove a resident (R2) in order to provide protection and immediately report the incident when physical abuse to R2 was witnessed as required by the facility abuse policy. These failures resulted in R2 being abused a second time by the same staff person (E4) for one of three abuse allegations reviewed and have the potential to affect all 68 residents cared for by E4. This failure resulted in	S9999		

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S9999	Continued From page 2 R2 suffering severe shoulder pain causing R2 to scream as a result of the physical abuse by a staff member. E1's (Administrator) Abuse/Neglect Investigation Report dated 3-3-16 regarding (R2) documents, "Investigation: 3/3/16 3:45 p.m. (E5/Licensed Practical Nurse) reported to (E6/Social Services Director) that an incident was reported to (E5) last night around 10:00 p.m. by (E3/Certified Nursing Assistant). (E3) witnessed treatment of a resident that (E3) did not feel was appropriate. (E6) reported incident to (E1/Administrator) immediately and initiated investigation...Initial report by witness: (E3) reported the following to (E5) at 10:00 p.m. on 3/2/16. (R2) was given a whirlpool bath around 8:30 p.m. on 3/2/16 by (E4 Certified Nursing Assistant). (E3) said (E3) entered the whirlpool room as (E3) heard (R2) yelling. (R2) was sitting on the bath chair and (E4) was working on getting (R2's) clothes off to begin bath. (E3) witnessed (E4) pulling (R2's) arm up and forcing (R2's) hand into (R2's) mouth. (E3) heard (E4) say, 'Go ahead bite yourself.' (E4) saw (E3) enter the room and stopped immediately and said, 'Don't even start I'm having a bad day.' (E3) left the room and returned to care for another patient. A few minutes later as (E3) was walking by the room (E3) witnessed (E4) spraying water directly in (R2's) eyes...Resident Interview: 3/3/16 4:00 p.m. (E6) interviewed (R2) about the incident during bathing on 3/2/16. (R2) said the following, '(E4) slaps and hurts me when (E4) takes my clothes off. Then it was blurry cause (E4) was spraying me with water in my face. I don't want (E4) to do anything for me anymore. (E4) acts this way every time and I'm scared.'...Perpetrator Interview: Called (E4) into (E1's) office at 4:05 p.m. 3/3/16 and asked if (E4) if there were any	S9999		

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S9999	Continued From page 3	S9999		

issues last night during bath given to (R2). (E4) said no. Asked if (E4) had sprayed (R2) in eyes. (E4) said no (E4) had washed (R2's) hair but not sprayed directly in face or eyes. Told (E4) that (R2) said (E4) was rough and slaps and hurts (R2) when undressing (R2). (E4) said no (E4) was not rough with (R2) and that (R2) doesn't like to take a bath so (R2) is resistant. (E4) said all CNA's (Certified Nursing Assistants) have trouble with (R2) at bath time. (E1) informed (E4) that (E4) was terminated immediately and to leave the facility at 4:10 p.m. 3/3/16."

On 3-16-16 at 10:00 a.m., R2 stated, "A few weeks ago a staff got rough with me. (E4) jerked my arms in the shower and hurt my shoulder. I told (E4) that (E4) hurt my shoulder, and then (E4) jerked my arm harder. (E4) then sprayed me in the the eyes with water and slapped me. (E4) was having a bad night and was taking it out on me. My shoulder hurts really bad."

On 3-16-16 at 10:00 a.m., E1 (Administrator) verified that on 3-2-16 around 8:00 p.m. to 8:30 p.m., (E3/Certified Nursing Assistant) witnessed E4 physically and verbally abusing R2. E1 verified that E3 reported the alleged abuse to E5 (Licensed Practical Nurse) that same night around 10:00 p.m, but (E5) did not report the incident until around 3:30 p.m. to 4:00 p.m. the next day (3-3-16.) E1 stated, " We (facility staff) have trained and trained on reporting of abuse. (E3) should have reported to the nurse when (E3) saw (E4) shove (R2's) hand to (R2's) mouth. (E3) should have pulled (E4) out of the shower room, initially, and reported to the nurse immediately. (E4) should have been suspended immediately. The incident should have been reported on 3-2-16."

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S9999	Continued From page 4	S9999		

On 3-16-16 at 2:20 p.m., E3 (Certified Nursing Assistant/CNA) stated, "On 3-2-16 (R2) was getting a whirlpool bath. I heard (R2) screaming, so I went into the shower room. I saw (E4/CNA) taking (R2's) shirt off. (R2) has a bad shoulder and cannot lift (R2's) arm that high, so (R2) was yelling in pain. (E4) lifted (R2's) arm to (R2's) mouth and was telling (R2) 'Bite yourself. I am not dealing with this today.' I walked out of the shower room and went to help another resident. I then heard (R2) screaming again, so I went back into the shower room. (E4) was spraying (R2) in the eyes with the shower hose. At that time I helped (E4) transfer (R2) to the chair, and myself and (E4) took (R2) to bed. (R2's) shower was around 8:00 to 8:30 p.m. that night. I told the nurse (E5/Licensed Practical Nurse) around 9:20 p.m. to 9:30 p.m. of this incident with (E4) and (R2). The incident caught me off guard. I was in shock. I know I should have removed (E4) from the situation and reported immediately, but did not."

On 3-17-16 at 9:20 a.m., E7 (Medical Director/R2's Physician) stated, "I expect residents most definitely to be free of abuse. This incident (3-2-16 incident between R2 and E4) is definitely considered abuse. (R2) has degenerate joint disease of both shoulders, gout, and is diabetic. (R2's) range of motion is very limited. Telling (R2) to bite self and spraying (R2) in the face is horrible. I do not know of any other definition of abuse besides these acts. The CNA should not have lifted (R2's) arm up to (R2's) mouth with as much pain as (R2) has in the shoulders. The CNA should have been removed from the shower room when the other CNA witnessed (R2) in pain and (E4) telling (R2) to bite self." During this same time, E7 stated, "Well it

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S9999	Continued From page 5 (incident 3-2-16) must have had some effect of (R2) to recall the event from 3-2-16. She does not normally have a good memory." The facility's Abuse and Neglect Prevention Policy, dated 12/4/14, documents, "It is the facility's policy to not tolerate verbal, sexual, physical, or mental abuse, involuntary seclusion or neglect of its residents by any individual...All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are to be reported immediately to the Administrator or his/her designated representative...The facility will protect residents from harm during the investigation of allegations with the following guidelines. The facility reserves the right to discipline, suspend or terminate any employee who the facility reasonably believes has abused, neglected, involuntarily secluded any resident or misappropriated any resident's property." (A)	S9999		

Imposed Plan of Correction
NAME OF FACILITY: Wesley Village
DATE AND TYPE OF SURVEY: March 21, 2016
IRI Investigation:
3/2/2016/IL84061

300.610a)
300.1210b)
300.3240a)
300.3240b)
300.3240c)
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 300.1210 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.

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.

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.

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.

Attachment B
Imposed Plan of Correction

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse or neglect 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.

This will be accomplished by:

I. Provide education for nursing staff on facility's policy and procedures on Abuse and Neglect, types of abuse, immediate reporting and removal of the perpetrator. Training to include education on signs of burnout or stress in caregivers.

II. Care plans to be updated on bathing needs/behaviors of residents and reviewed with Certified Nurses Aide's.

III. Certified Nurses Aide's to be trained to meet the bath/shower needs of the resident.

IV. Director of Nursing or Designee will conduct random audits to ensure compliance.

V. Director of Nursing will be responsible for achieving and maintain compliance.

VI. Facility Administrator to provide oversight for continued compliance.

Date of completion: Ten days from receipt of the Imposed Plan of Correction

May 17, 2016/JP

Attachment B
Imposed Plan of Correction