

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/23/2016
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NAME OF PROVIDER OR SUPPLIER SELECT POST ACUTE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MAIN STREET EUREKA, IL 61530
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S 000	Initial Comments First Probationary Licensure Survey. Select Post Acute Care is in compliance with the Sheltered Care Facilities Code (77 Illinois Administrative code 330) for the survey.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.3240a)b)d)e) Section 300.3240 Abuse and Neglect a) b) d) e) 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) 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) 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) This requirement was not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>Based on observation, interview and record review the facility failed to: prevent verbal and physical abuse, report abuse immediately to the Administrator and to the State Agency, remove the alleged abuser from contact with residents, and ensure staff received training on reporting abuse. These failures affected one resident (R1), who developed bruising after being physically and verbally abused by E6. This failure also had the potential to affect the other 69 residents in the facility when E6 was not removed from contact with residents for five hours.</p> <p>Findings include:</p> <p>An Abuse Program policy dated 9/2016 states, "The facility affirms the right of our residents to be free from verbal, sexual, physical, emotional, mental abuse...Residents must not be abused by anyone, including but not limited to, facility staff...The facility provides to residents, families and staff information on how and to whom they may report concerns, incidents and grievances...The staff will receive training on issues related to abuse prohibition practices during orientation and as ongoing training of employees...The facility will cover the following topics: How to report suspicion of inappropriate care/behavior...Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about or suspect...to a supervisor or the administrator...If there is a possibility of abuse the staff member will be sent home pending the results of the investigation...If abuse is suspected (The State Agency) is to be notified immediately...After immediate notification a preliminary abuse investigation is initiated..."</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>R1's current list of diagnoses includes Dementia without Behaviors, Cognitive Communication Deficit, and Anxiety.</p> <p>R1 ' s Minimum Data Set (MDS) assessment documents R1 is severely cognitively impaired. On 11/21/16 at 9:30a.m. R1 was walking independently in and out of R1 ' s room, without purpose, appeared confused, and was speaking using incomprehensible sentences. R1 was unable to answer questions appropriately.</p> <p>R1's abuse investigation dated 11/6/16 documents that on that date at 1:00a.m. R1 was "wandering around" the facility attempting to close fire doors in the hallway. The investigation documents that E4 (Certified Nurse Aide/CNA) witnessed E6 (Licensed Practical Nurse) grab R1 by the arm and yell at R1 to not close the fire doors. The investigation documents that E4 stated that when E6 grabbed R1, R1 almost fell. The investigation also documents that R1 called E6 an "idiot" to which E6 responded with, "You are the idiot." The investigation documents that E6 was interviewed two separate times and gave inconsistent stories. The investigation documents R1 developed four bruises to the right upper arm, "...which were consistent with the statement provided by (E4)..." The investigation documents that E7 (CNA) who had cared for R1 on 11//6/16 noted R1 had developed, "...a large bruise under her right arm." The investigation documents E8 (Registered Nurse) stated that during a nurse to nurse report at 6:00a.m. on 11/5/16 E6 told E8 that E6 was going, "...to retaliate and get E4 in trouble if she (E6) was going to get in trouble." The investigation documents the allegation of abuse against R1 was substantiated as a result of E4's eye witness account, E6's inconsistent story, and R1's right upper arm bruising. The investigation documents</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>that R1 has severe cognitive impairment and is unable to recall the events from 11/6/16. R1's abuse investigation fax date stamp documents the facility initially notified the State Agency 11/7/16 at 12:31p.m.</p> <p>E4's witness statement (undated) documents that on 11/7/16 at approximately 12:30a.m. E4 witnessed R1 closing the fire doors on hall 2. E4 stated that E4 witnessed E6, "... grab (R1) by the right upper arm and jerked her away from the door yelling at her...E6 continued yelling at R1. When (R1) tried to pull her arm away from E6, (R1) almost fell. As R1 was walking away, R1 called E6 an idiot. Then E6 replied, 'No you're the idiot.'" E4's statement also documents that E4 tried to notify E2 (Director of Nursing) on the phone to report alleged abuse, but when E2 did not answer her phone, E4 sent E2 a text message. E4's statement also documents that E4 called the facility's abuse hotline and reported the alleged abuse by leaving a message. E4's statement does not document that E4 tried to notify E1 (Administrator) of the allegation of abuse.</p> <p>R1's Injury report dated 11/7/16 documents R1 had developed four new bruises to the right upper arm.</p> <p>On 11/22/16 at 8:10a.m. E4 clarified the date E4 witnessed E6 abuse R1 was between 12:30a.m. and 1:00a.m. on 11/5/16. E4 stated 11/7/16 was when she gave her written account from the incident on 11/5/16. E4 stated that R1 is a confused resident with dementia who is independently mobile and often wanders around the facility at night. E4 stated that at approximately 12:30a.m. to 1:00a.m. on 11/5/16 R1 was walking in the hall and trying to close the</p>	S9999		

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S9999	Continued From page 4 fire doors. E4 stated that both she and E6 approached R1 at the same time. E4 stated that E6 grabbed R1 and started yelling at R1. E4 stated that R1 didn't understand why E6 was yelling at her because R1 is confused and has dementia. E4 stated that R1 kept saying, "It's OK my husband said so." E4 stated that E6 continued to grip R1's arm and yell at R1. E4 stated that R1 pulled her arm free of E6 at which time E4 started walking away, with R1 at her side. E4 stated that R1 called E6 an "idiot" as she walked away to which E6 responded, "No, you're the idiot." E4 stated she took R1 to the lobby to sit in a chair with a blanket. E4 stated that, "(R1) kept looking around for (E6) and was so scared." E4 stated, "I was trying to figure out who to call because E6 was the only supervisor here. Everyone else was a CNA. Another CNA told me to call E2. I tried to call E2 three times but when she didn't answer I sent her a text message." E4 stated that when E4 could not get in touch with E2, another CNA suggested E4 call the facility's abuse hotline. E4 stated the abuse hotline phone number belongs to E5 (Marketing Director). E4 stated she left a message on E5's voicemail but did not receive a return phone call. E4 stated she considered calling the police because E4 didn't think E6 should be caring for the facility's residents after verbally and physically abusing R1. E4 stated that E6 was aware that E4 was going to report E6 for abusing R1. E4 stated that while she was providing care for a resident at around 5:00a.m., E6 entered the room and told E4 someone was waiting to see E4 at the nurses' station. E4 stated that when E4 went to the nurses' desk a policeman was waiting for her. E4 stated the policeman said E6 had reported that E4 had left her child at home alone without food, water, or heat and that E4 would have to leave the facility with the officer to check on E4's	S9999		

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S9999	<p>Continued From page 5</p> <p>son. E4 stated she left the facility with the policeman at approximately 5:30a.m. on 11/5/16. E4 stated that E4 is a new CNA and has worked at the facility since 8/2016. E4 stated she did not receive any instructions during orientation on how to report abuse or who to report abuse to.</p> <p>E4's timekeeping record confirms E4 clocked in at 9:50p.m. on 11/4/16 and clocked out at 5:23a.m. on 11/5/16.</p> <p>On 11/22/16 at 12:14p.m. E5 stated the abuse hotline number calls the phone in E5's office at the facility and then is redirected to her cell phone after hours. E5 stated that on 11/5/16 between 12:00a.m. and 6:00a.m., E5 was at home asleep, and did not hear the phone ring when E4 called to report the allegation of abuse. E5 stated she did not listen to E4's message until sometime around 7:00a.m.. E5 stated, "I don't handle the abuse investigations. I'm just a dispatcher for the abuse hotline. I get the call and I let the Administrator know and that ends my involvement."</p> <p>On 11/21/16 at 11:10a.m. E2 (Director of Nurses) verified E2's investigation substantiated that E6 verbally and physically abused R1 on 11/5/16 at approximately 1:00a.m. E2 stated that E4 did not notify E1 (Administrator) or E2 immediately after E4 witnessed E6 abuse R1. E2 stated that E4 sent a text message to E2's phone and also called the abuse hotline. E2 stated that E2 did not hear her phone ring since it was the middle of the night and she was asleep. E2 stated that she only became aware that E6 had abused R1 after arriving at the facility later that morning. E2 stated that E6 was not suspended at the time of the abuse, and continued to work until the end of her shift. E2 stated that E6 was the only nurse on duty that night (11/5/16) and was caring for all residents in the facility.</p>	S9999		

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S9999	Continued From page 6 On 11/21/16 at 2:50p.m., 11/22/16 at 11:20a.m and 1:40p.m., E1 (Administrator) verified the date of E4's allegation of abuse between E6 and R1 occurred 11/5/16 at approximately 1:00a.m. E1 also verified that E1 was not notified immediately by E4 that abuse occurred. E1 stated that he was not notified of the alleged abuse until later in the morning at approximately 10:00a.m by E2. E1 verified the abuse hotline does not notify E1 directly when there is an allegation of abuse. E1 stated that the abuse hotline is actually E5's phone number. E1 stated that once E5 receives an allegation of abuse, E5 is supposed to contact E1 so an investigation can be initiated. E1 stated E5 did not contact him with E4's allegation of abuse. E1 verified the allegation of abuse by E6 to R1 was substantiated, "... because of the eye witness statements and the bruising to (R1)'s arm which was consistent with E6 grabbing (R1)'s arm." E1 verified E6 was allowed to work until the end of her shift at 6:00a.m. on 11/5/16. E1 stated E6 should have been removed from the facility immediately pending an investigation. E1 stated he was unable to provide documentation that E4 received abuse training during her new employee orientation 8/2016. E1 stated the State Agency should have been notified immediately with the allegation of abuse between E6 and R1. E1 verified the State Agency was not notified until 11/7/16. A Detailed Census Report dated 11/5/16 and signed by E1 documents that at the time of the abuse, 70 residents resided in the facility. (B)	S9999		

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S9999	<p>Continued From page 7</p> <p>300.650a) Section 300.650 Personnel Policies a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section. This requirement is not met as evidenced by: Based on interview and record review the facility failed to complete new orientation process and training of abuse for one of one employee (E4) reviewed for abuse education. Findings include: The facility's Abuse Program, Prevention, Investigation, Reporting Policy, dated 9/2016, documents "Training Employees. The staff will receive training on issues related to abuse prohibition practices during orientation and as ongoing training of employees...What constitutes abuse, neglect and misappropriation of residents' property...How to report suspicion of inappropriate care/behavior to the appropriate authorities." The facility's Nurse Aide Roster, provided by E2, Director of Nursing, on 11/21/16, documents that E4 Certified Nursing Assistant, was hired on 8/11/16. On 11/22/16 at 8:10am, E4 stated that E4 did not receive any abuse training from the facility, and was unsure as what to do in the case of an alleged abuse. On 11/23/16 at 10:30am, E2, verified that E4 has not completed any orientation process, including abuse training.</p> <p>(AW)</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>'Section 300.696a)</p> <p>Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.</p> <p>This requirement is not met as evidenced by: Based on observation, record review and interview, the facility failed to perform hand hygiene during a medication pass for two of two residents (R4 and R7) reviewed for medication administration in the sample of seven and two residents (R8 and R9) on the supplemental sample.</p> <p>Findings include: The facility's Administering Medications policy (revised 12/2012) documents the following: "Medications shall be administered in a safe and timely manner, and as prescribed... Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable..." The facility's Handwashing/Hand Hygiene policy (revised 8/2014) documents the following: "Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>situations: Before preparing or handling medications..."</p> <p>On 11/21/16 at 3:25 PM, E3 (Registered Nurse) prepared and administered R8's medications. Once E3 completed R8's medication administration, E3 returned to E3's medication cart and prepared and administered R7's medications. After E3 administered R7's medications to R7, E3 returned to E3's medication cart and prepared and administered R9's medications. When E3 was finished administering R9's medications, E3 returned to E3's medication cart and prepared and administered R4's medications. E3 did not perform hand hygiene prior to administering medications to R8, R7, R9 or R4.</p> <p>On 11/21/16 at 3:55 PM, E3 stated that E3 typically performs hand hygiene between resident medication passes. E3 confirmed that E3 did not perform hand hygiene when administering R8, R7, R9 and R4's medications and stated that E3 should have performed hand hygiene between those medication passes.</p> <p style="text-align: center;">(C)</p> <p>Section 300.2100</p> <p>Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).</p> <p>These requirements were not met, as evidenced by:</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>These failures resulted in two deficient practices:</p> <p>1. Based on observation, interview and record review the facility failed to: keep Cooling Temperature Logs for Potentially Hazardous Foods for a minimum of one year; follow their Food Storage policy to label and date food items in the refrigerator and to discard food in the refrigerator that was outdated; and maintain a clean can opener. This has the potential to affect all 70 residents in the facility.</p> <p>Findings include:</p> <p>"Food Service Sanitation" (77 Ill. Adm. Code 750) includes the following in APPENDIX A Food Establishment Inspection Report Cooling Temperature Log Record the date, food items(s) and the time and temperature every 4 hours of the cooling cycle. This product has four hours to cool from 140° F to 41°F. Refer to the Cooling Potentially Hazardous Food SOP for corrective actions if product is not cooling properly. The food service manager will verify that the food service staff is cooling food properly by visually monitoring food service employees during the shift and reviewing, initialing, and dating the log. Maintain this log for a period of one year.</p> <p>The facility's policy titled Food Storage: Cold, dated 5/2014 states, "The Food Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated..."</p> <p>The facility's policy titled Food: Preparation, dated 5/2014 states, "...foods that are to be held for more than 24 hours...will be labeled and dated with a "prepared date" (Day 1) and a "use by</p>	S9999		

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S9999	<p>Continued From page 11 date" (Day 7).</p> <p>On 11/23/16 at 11:20 a.m., E10 (Dietary Manager) stated, "We do not have a written facility policy which describes cleaning the kitchen, kitchen appliances, and the facility's upstairs dining room."</p> <p>On 11/21/16 at 9:15 AM the three door reach-in refrigerator contained: six boiled eggs and one pound of parmesan cheese without a label or date; three pounds of Blue cheese, open date 10/10/16; one pound of shredded Mozzarella cheese open date 10/10/16; three pounds of Parmesan cheese open date 10/30/16; three pounds of sliced American cheese open date 10/30/16; two pounds of ham open date 11/01/16; one pound of sliced cheese open date 11/11/16.</p> <p>On 11/21/16 at 9:15 AM E10, verified these items should have been discarded stating, "Our policy is to label and date the food when opened and to discard opened food items after seven days."</p> <p>On 11/21/16 at 10:45 AM the can opener had a black sticky build up of food debris on the blade area and on the table base. The E10 verified that the can opener was dirty and should have been cleaned.</p> <p>A signed census signed by E1 (Administrator), dated 11/21/16 documents that there are 70 residents residing in the facility.</p> <p>2. Based on observation, interview and record review the facility failed to maintain a sanitary and clean area in the facility's upstairs dining room satellite kitchen which served four residents (R1,R3,R5,R6) in a sample of seven and 28</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER SELECT POST ACUTE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MAIN STREET EUREKA, IL 61530
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(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	<p>Continued From page 12</p> <p>residents (R8,R10,R11,R13,R18-R45) in the supplementary sample.</p> <p>On 11/21/16 at 11:20 AM, the facility's upstairs dining room satellite kitchen was not clean and had splashes on the entrance door and cabinets (dried food particles and dried dripped liquid of unknown food type) including a build up of dried food debris in the kitchen sink, microwave, sneeze guard, steam table and refrigerator. The refrigerator contained: a styro-foam container, lid flipped open exposing a dark brown/black dried out beef sandwich, no identifying label or date; three four ounce containers of a thawed frozen supplement without a thaw date; a 24 ounce bottle of apple juice with the open date 11/12/16; a quart of half and half cream, three fourths full with the open date 10/27/16.</p> <p>On 11/21/16 at 11:50 AM E10, verified the dirty condition of the upstairs dining room satellite kitchen and the undated/outdated items in the refrigerator stating, "This is not acceptable, staff know to label and date food, discard food in seven days and to keep the kitchen area clean."</p> <p>(B)</p>	S9999		