STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005987	A. BUILDING: _____ B. WING _____	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWOOD	320 SECOND STREET GRAYVILLE, IL 62844

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review the facility failed to prevent incidents of abuse resulting in bruising, involuntary seclusion, and/or mental anguish for 6 of 6 residents (R1, R2, R3, R4, R5, and R6) reviewed for abuse in the sample of 7. These failures resulted in psychosocial harm for R2, in that, a reasonable person would react to such physical and mental abuse with such feelings as agitation, anxiety, frustration, fearfulness, humiliation and punishment.

Findings Include:

1. R2's Face Sheet documents the diagnosis as Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Alzheimer's, Disease, history of Cerebral Vascular Disease, Anxiety, Insomnia, and Depression. The Minimum Data Set, dated 3/14/17, documents that R2's Brief Interview for Mental Status, Section C Cognitive Pattern, is 3 of 15 indicating resident's cognitive ability is severely impaired. Section E, Behavior, documents that R2 has Delusions and Wandering Behaviors that places resident at significant risk of getting into dangerous places and intruding on the privacy or activities of others.

R2's Universal Progress Record and Consultants Report, dated 4/18/17 1:00PM, documents

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S9999	Continued From page 2	S9999		

bruising to R'2s arms and hands, scattered, dark purple in color, bruising noted of unknown origin. The Wound Flow Sheet, undated, documents bruising on 4/18/17 to the Bilateral Upper Extremities. The bruising is documented as scattered and purple. The entry on this same report dated 5/1/17 documents the scattered bruising to the Bilateral Upper Extremities as fading.

The Abuse, Neglect, and/or Theft Incident Reporting Form documents that 2 CNAs (E4 and E3, Certified Nurse Aides) witnessed a nurse (E5) and CNA (E6) walk a resident, R2, to her room with excessive force. The report further documents new bruises noted to R2's bilateral wrist and forearms. There is no documentation of the date or time that this incident occurred. The form indicates that E2 (Director of Nursing) was not notified until 5:45AM on 4/18/17 by E4 (CNA/Certified Nurse Aide). On 5/2/17 at 8:30 AM, E2 (Director of Nurses) stated she was notified on 4/18/17 at 5:30 AM when she arrived at the facility. E2 stated she notified E1 (Administrator) at 5:45AM on 4-18-17. E2 stated the incident occurred on 4/17/17 between 10:00PM and 10:30PM. E5 and E6 were called on 4/18/17 in the afternoon and both employees resigned.

On 5/1/17 at 8:10AM, E1 (Administrator) stated that there is no charting regarding the 4-17-17 incident in R2's records and no documentation of behaviors during that shift on 4/17/17-4/18/17. He went on to say that "we recently put an extra CNA on nights to catch E5's bad behavior, for possibly yelling at residents." On 5-1-17 at 12:05PM, E1 stated that when they did the investigation regarding abuse, the residents questioned were

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S9999	Continued From page 3	S9999		

not specifically asked about E6 and E5 being abusive, the residents were only questioned about staff in general. E1 went on to say this is the way he has always performed an abuse investigation. During this same interview, E1 stated after reviewing the file once IDPH entered on this complaint, that he then reported E5 to the State Board of Nursing and E6 to the Health Care Registry and Department of Public Health, Region 5. E1 further stated that law enforcement was not notified of the incident either.

E3's (CNA) written statement dated 4/20/17 documents that on 4/17/17 she was sitting with R2, and R2 was looking at a picture book. Sometime after that R2 got up and walked over to a little table where E5 was sitting. R2 was going to say something or ask something and didn't get a chance because E5 got up quickly and 'took a hold' of one side of R2 and E6 (CNA) the other side and took R2 to her room. I asked E5 maybe there was a better way to handle R2 and why didn't they just let her talk. E5 told her it was handled this way because R2 won't do what you need her to do, and you just have to tell her what to do or to do it, that this is the only thing R2 understands. After awhile R2 got up, and came out of her resident room and came back out to the day room and they told her to go and they both took her back to her room. On 5/2/17 at 2:20PM, E3 (CNA) stated that the incident happened on 4/17/17 about 10:00 to 10:30PM. She went on to say that E5 was annoyed, got up very fast and took hold of R2's arm and another CNA took the other arm and they walked R2 to her room. E3 stated R2 was not happy and didn't want to go with them. E3 stated she was very alarmed because she felt R2 could have been handled differently or talked to more calmly.

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S9999	Continued From page 4	S9999		

On 5/1/17 at 3:10 PM E4 (Certified Nurse Aide) stated, that she was sitting in the Day Room on 4-17-17 at approximately 10:00 pm, when R2 walked up to where E5 (Licensed Practical Nurse) and E6 (Certified Nurse Aide) were sitting when E5 stated "we are not having that tonight". E4 stated that E5 and E6 both grabbed R2's wrist and dragged her to her room. Soon R2 came out of her room and E5 grabbed R2's wrist and E6 grabbed R2's elbow, forcing her back into her resident room. About 5 minutes later E5 and E6 were in R2's room and R2 fell into bed with force. E4 stated due to darkness she was unable to see how or why that occurred. E4 stated she checked R2's wrist and forearm and noted 'hand mark bruising' to her wrist and forearm. She stated she reported it to E2 (Director of Nurses) about 5:30AM on 4/18/17 and to E1 later in the morning on 4/18/17.

On 5-2-17 at 10:00 am, an interview was attempted with R2, due to R2's cognitive loss, R2 could not express how she felt to be physically abused and secluded in her room on 4-17-17.

A reasonable person would react to such physical abuse and seclusion with such feelings as agitation, anxiety, frustration, fearfulness, humiliation and punishment.

2. On 5/1/17 at 11:00AM, R1 stated that E5 would take his 2 water pitchers away from him when she came in to work in the evenings and gave me a small glass of water. "I begged her not to because I have 3 kidneys and I have to have the extra water, if not my urine turns brown". She also told me and R5 that she was not going to take any crap from me, that she was in a bad mood. R1 stated "I was afraid she would not help me if I

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S9999	Continued From page 5	S9999		

reported her, so I did not report anything" R1's Brief Interview for Mental Status (BIMS) dated 4-14-17, scores R1 as 15 out of 15, meaning R1 is cognitively intact.

3. On 5/1/17 at 10:05 AM, R6 stated that E5 was very rude and cross if you needed something. E5 had a mean voice and gruff, and the residents are glad she is gone. E5 would say things that made you feel bad. R6 stated "If E5 was having a bad day she made sure everyone was having a bad day too." R6, when asked if it had been reported, would not answer. R6's Brief Interview for Mental Status (BIMS) dated 4-7-17, scores R6 as 12 out of 15, meaning R6 has moderate impaired cognition.

4. On 5/1/17 at 10:20AM, R4 stated that E5 was very rude when I asked for a beer stating "Do I look like a bartender" also if I asked for a pain pill she would ask me "Do I look like a pharmacy". R4 went on to say that E5 would yell up and down the halls in the evenings. R4 also stated that E5 would target R5 with nasty comments like "I know you pissed in your chair so you could go out to smoke". R4 stated she really got tired of E5's bad mouth and attitude. R4's Physician's Orders dated 5/1/17 through 5/31/17, documents Ibuprofen 200 milligrams, take 2 tablets by mouth three times a day as needed. The Physician Order also documents Beer, may have 4 per day, 2 around noon, 2 in the evening, not all at one time. R4 states the incidents were not reported and did not provide a reason why they were not reported. R4's Brief Interview for Mental Status (BIMS) dated 2-23-17, scores R4 as 15 out of 15, meaning R4 is cognitively intact.

5. On 5/1/17 and 5/2/17 R5 stated, that E5 was mean to a lot of people and she would say mean

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S9999	Continued From page 6	S9999		

stuff to me but I'm tough and I ignored her. R5 did not report the incidents and did not provide a reason why they weren't reported. R5's Brief Interview for Mental Status (BIMS) dated 4-3-17, scores R5 as 15 out of 15, meaning R5 is cognitively intact.

6. On 5/1/17 at 9:15AM,R3 stated that "E5 is gone and I am glad". R3 also stated she was taking a Blood Pressure Medication that caused her to have bad dreams and crawl on the floor. E5 would tell me that I was doing it to get attention. E5 was a hell cat and hell on wheels. She frequently told me no one liked me and that I was acting like a queen. R3 then showed the surveyor a page from her journal dated April 2016 and read it to me. R3's journal documented that E5 told her 1. No one liked her (night crew and day crew), The staff regards me as someone who thinks they are a Queen and expects everyone else to wait on them, and 3. They are considering putting R3 in another room because she is lonely and that is why she was having these spells at night because she wants attention. R3 also stated "E5 really made me think I was a bad person". R3 stated that the incidents were not reported because E5 made me feel bad enough. R3's Brief Interview for Mental Status (BIMS) dated 4-13-17, scores R3 as 15 out of 15, meaning R3 is cognitively intact.

The Resident Abuse or Neglect policy, dated 3/1/17, documents the following: It is the policy of this facility to protect the residents from verbal and physical abuse. This shall be achieved by appropriate screening and training employees who participate in resident care. Appropriate intervention, identification, investigation, protection and reporting will be utilized. If there is reasonable suspicion that the injury is a result of

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S9999	Continued From page 7 a crime, then law enforcement shall be notified as well. If the events that cause reasonable suspicion of a crime, but do not result in a serious bodily injury to the resident, the facility shall report the suspicion not later than 24 hours after forming the suspicion to the Illinois Department of Public Health and law enforcement. The facility shall report to the State Nurse Aide Registry or Professional Regulation any knowledge it has of any actions by a court of law which would indicate an employee unfit for service. (B)	S9999		