Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002539	A. BUILDING: ______ B. WING ______	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCTORS NURSING & REHAB CENTER	1201 HAWTHORN ROAD SALEM, IL 62881

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S 000	Initial Comments Complaint Investigations: 2153620/IL134268 2153589/IL134228	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide resident care in a timely and dignified manner for 3 (R4, R6, R2) of 5 residents reviewed for resident care in the sample of 10. The failure resulted in psychosocial harm as evidenced by R4 experiencing expressions of embarrassment, negative statements, tearfulness, and reports of crying, along with R6 experiencing tearfulness.

Findings Include:

1. On 5/27/21 at 11:05 AM, R4 states she is continent of urine and bowel, but due to lack of timeliness in assistance being provided to the restroom, she has experienced episodes of incontinence. R4 states she requires staff assistance with transferring and finds although she illuminates her call light as soon as she has the indications she will need to use the restroom, the untimeliness of staff response, along with her consumption in taking a "water pill" make it so she cannot wait for long periods of time. R4 states her most recent incontinent episode at the time of this interview was on 5/26/21, and then a couple weeks prior to that. R4 states she finds the incontinence embarrassing. R4 recalls an incident when she states she was apologetic to staff by saying "Sorry, I couldn't hold it any longer and dirtied the bed." R4 states the staff responded by stating, "I know, I can smell it." R4 then stated, "Things like that just don't make a person feel good." R4 states she waits anywhere

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from 15 minutes to over an hour for her call light to be answered. R4 states she presented her concerns to V2 who told her to remember she isn't the only one here. During this interview, R4 was alert and oriented to person, place, and time.

On 5/28/21 at 7:55 AM, R4 states yesterday evening she had an episode in which she urinated in her clothes waiting for her call light to be answered. R4 states she kept seeing staff walk by her room and was trying to holler at them too, even though her light was on to let them know she couldn't hold it, but states they kept telling her she would have to wait a minute. R4 states after urinating and being left sitting in her wet clothes, she used her cell phone and called the nurses station and talked with V10 (Licensed Practical Nurse) to let her know she needed help. R4 states at that point, she broke down and began crying because she is frustrated, mad, and embarrassed that a "grown woman has to sit there and pee her pants!" R4 states she is working hard with therapy to try and be able to transition back home, and to soil her clothes makes her feel like she is going backwards. R4 is observed as again becoming tearful and raising her voice during this time.

On 5/28/21 at 12:07 PM, V10 confirms she did work on 5/27/21, and received a phone call around 7 PM from R4 stating she was upset, had wet herself, and was wanting to be put to bed. V10 states staff were on the hallway where R4 resides tending to other residents. V10 states she told the staff members R4 needed assistance and she would help if needed. V10 states she was getting ready to leave for the day though, so she just went and checked on R4 to let her know she had spoken with staff and they would be heading her way. V10 states the facility needs more staff

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to meet resident care needs.

2. On 5/28/21 at 12:15 PM , R6 describes an episode of experiencing rough care as, "Leaves me on the bedpan for long time. Other night for 2 hours." When asked if R6 turns on R6's call light when done R6 states, "Yes." When asked how R6 determined the time frame of 2 hours, R6 states, "Clock," and a clock is observed on a wall within viewing distance of the bed. R6 states, "Yes" when asked if R6 has been left on the bedpan for an unacceptable amount of time more than once. When asked does this upset you, R6 states, "Yes. It uncomfortable." R6 also states "Yes" when asked if it interrupts R6's sleep. R6 states V3 (Certified Nurse Assistant) was the staff member who responded to R6 light and removed the bedpan. During this interview, R6 was observed as being alert and oriented to person, place and time.

On 5/28/21 at 1:25 PM, V3 states the facility does not have enough staff to meet resident needs. V3 states call lights are not answered in a timely manner, nor are residents changed and/or repositioned as they should be. V3 states an incident occurred a few nights ago where she responded to R6's call light and when she entered R6's room, she noted R6 face to be red with R6 on the verge of tears. V3 states she asked R6 what was wrong in which R6 responded "bedpan." V3 states she asked R6, you want on the bedpan? V3 states R6 stated, "off!" V3 states, "I wasn't trying to be an a-hole. I didn't know she was on there. I don't know who put her on there." V3 states she asked R6 how long R6 had been on there and states R6 said, "Awhile!" V3 states she removed the bedpan and continued working. V3 confirms R6 is cognitively intact and utilizes the call light. V3 states that R6

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S9999	Continued From page 4 just has trouble "getting out what R6 wants to say." 3. On 5/27/21 at 11:29 AM, R2 states the facility does not have enough staff to respond to call lights in a timely manner. R2 states she would say on average it takes about 20 minutes for her call light to be answered. During this interview. R2 was alert and oriented to person, place, and time. On 5/27/21 at 8:48 AM, V2 (Director of Nursing) states current staffing levels at the facility "probably don't meet resident needs." V2 states the facility has attempted to hire more staff, along with utilize agency staff, but states they receive little to no applicants, and agency staff don't always show up to work. V2 states resident needs aren't met by evidence of call light timeliness could be improved. V2 states she has received complaints specifically from R4 regarding her call light not being answered in a timely manner. V2 also states resident showers may not be given on their scheduled days as staffing may not be available for showers on those days but will be given on a later day to fulfill the twice weekly showering requirement. At 2:52 PM on the same day, V2 states staffing levels are based off facility census versus resident acuity. On 5/28/21 at 8:24 AM, V6 (Certified Nurse Assistant) states there are days the facility does not have enough staff to meet resident needs. V6 states staff just "Have to do what we can." V6 states, "Things cannot get done the way they need to be done." V6 goes on to state this statement includes call lights not being answered in a timely manner and residents not being taken to the toilet in a timely manner. V6 states she is aware of instances in which normally continent residents experienced incontinent episodes due	S9999		

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to not being taken to the toilet timely. V6 states there are times showers are unable to be completed on designated shower days due to not being enough staff. V6 states staff will attempt to make up the showers on another day or give resident's bed baths.

On 5/28/21 at 10:20 AM, V12 (Licensed Practical Nurse) states with the current facility staffing levels, staff are unable to meet resident needs. V12 states she works night shift and had notified V2 of her staffing level concerns recently via phone when V2 has told her to call people in. V12 states, there was no one to call in though, and management didn't come in to help. V12 states resident call lights are not answered in a timely manner, nor are residents turned and repositioned as they should be.

On 5/28/21 at 11:31 AM, V14 (Licensed Practical Nurse) states the facility needs more staff, and should the facility be adequately staffed, the quality of care provided to the residents would be improved.

On 5/28/21 at 3:00 PM, V2 states her expectation would be for call lights to be answered within 5-7 minutes. V2 states once a resident is done on the bedpan and turns on their call light for service, the expectation response time by staff for bedpan removal would also be 5-7 minutes. V2 acknowledges being left on the bedpan for an extended period can result in pain and discomfort.

On 6/1/21 at 10:15 AM, V1 (Administrator) states the facility is staffed as best as they can get it right now. V1 states he has received resident complaints regarding call lights not being answered in a timely manner. V1 states his

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expectation is for call lights to be answered in less than 5 minutes.

Review of the facility policy titled "Answering the Call Light", with a revision date of July 2014, states: "The purpose of this procedure is to respond to the resident's requests and needs" The policy goes on state ... "8. Answer the resident's call as soon as possible. 9. Be courteous in answering the resident's call." Steps in the procedure include, "3. Listen to the resident's request. 4. Do what the resident asks of you if permitted. 5. If you have promised the resident you will return with an item or information, do so promptly. 6. If assistance is needed when you enter the room, summon help by using the call signal."

In an article titled "Nursing Bedpan Management", with an update date of July 31, 2020, and found at
https://www.ncbi.nlm.nih.gov/books/NBK499978/
states, "The important features of bedpan are not only to provide a functional use for the patient, but comfort and privacy. If a bed pan is to be used, it should be for a short duration. there are countless cases of pressure sores, ulcers and neuropathy from patients being left too long on the bed pan."

(B)

2 of 2

300.610 a)
300.3240 a)

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

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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.

Based on observation, interview, and record review, the facility failed to prevent staff to resident abuse for 3 (R4, R5, and R6) of 6 residents reviewed for abuse in the sample of 10. This failure resulted in psychosocial harm as evidence by observed tearfulness along with feelings of fear for R6.

Findings Include:

1. On 5/27/21 at 11:41 AM, R6 is alert and oriented to person place and time. R6 understands speech and responds appropriately, but has difficulty speaking and expressing thoughts. An interview with R6 transpired which included the following information:
Are you happy with your care at the facility? "No"
Is anyone at the facility mean to you? "Yes"
Do they work during the day or night? "Night"
What is their name? No response
Is it Susie? "No"
Is it "(V3 first name)"? "Yes"
Is it Lisa? "No"
Is she the only person who is mean to you? "Yes"

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How is she mean? "She yells at me. Rude. Says WHAT DO YOU WANT NOW! I'M THE ONLY ONE HERE!" Inaudible vocalization continued. R6 became tearful during this time.
Do you feel what she says is abuse? "Yes"
Did she speak to you this way only one time? "No"
What night did this occur? "Most nights. She's not nice."
Do you feel fearful of her or afraid she would hurt you? "Yes"
Has she ever physically assaulted you assaulted you in any manner? "No"
Have you told anyone about the trouble you've had with "(V3 first name)"? "No"
Is it ok that I speak with the facility about the trouble you've had with "(V3 first name)"? "Don't use my name."
Can I use your name in my investigation findings? "No."
Are you afraid they would treat you differently then? "Yes."

Review of R6's Minimum Data Set, dated 12/19/20, documents a Brief Interview for Mental Status Score of 14, indicating she is cognitively intact. Review of R6's Diagnosis includes but is not limited to Aphasia following cerebral infarction.

2. On 5/27/21 at 12:50 PM, R5 states she has had many problems with a night shift aide named "(V3's first name)." R5 states she has expressed her concerns to V1 (Administrator) and V2 (Director of Nursing) regarding staff attitudes in general, in which they said they would address the staff, but states she learned, "you just have to have thick skin in the nursing home." R5 describes V3 as making you feel as though you are a bother. R5 states she is very rude and

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handles her "rough." R5 states when she turns on her call light for assistance, V3 will respond by coming in her room stating, "What do you want this time?" R5 also describes an incident in which she wanted to utilize the bedpan differently than how V3 had placed it for comfort reasons. R5 states when she requested to have the bedpan position changed, V3 stated in a very hateful tone, "Well don't fart in my face!" R5 states at times she feels the way V3 has spoken to her is in an abusive manner. R5 states she often wondered if it was only her V3 treated this way, or if there were others too. R5 states she is relieved now though because V3 is leaving from the facility so "she is someone else's problem now." R5 states while some other aides can have poor attitudes, V3 is the only one she would consider being abusive at times. R5 states there is no specific dates she can pinpoint the abuse as occurring as V3 is unpleasant more often than not. R5 is alert and oriented to person, place, and time during this interview.

Review of R5's Minimum Data Set, dated 11/24/20, documents a Brief Interview for Mental Status score of 15, indicating she is cognitively intact.

3. On 5/28/21 at 1:00 PM, R10 states she has had problems with V3 (Certified Nurse Assistant) and expressed concern to V10 (Licensed Practical Nurse) with the way she hears V3 speaking to other residents. R10 describes V3 as having a horrible attitude and states she "will get loud with you." R10 states in expressing her concerns to V10 she hoped something would be done with V3. R10 states V3 works night shift and she overhears V3 speaking so loudly to residents during the night saying things like, "I get tired of this all the time!" "I already know what you want!"

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R10 states the manner in which she hears V3 speaking to residents she would consider abusive. R10 states, "Nobody deserves to be talked to like that." R10 is alert and oriented to person, place, and time during this interview.

On 5/28/21 at 12:07 PM, V10 verifies she has received a complaint from R10, along with R4 regarding V3, but states she took them more as they just didn't get along with her, not as being abusive in nature.

4. On 5/27/21 at 11:05 AM, R4 describes V3 as, "She has no business working in a nursing home!" R4 states she hears V3 speaking to residents in a tone that is not friendly and is rude. R4 states that she has also observed V3 handle residents roughly. R4 is alert and oriented to person, place, and time during this interview.

On 5/28/21 at 1:25 PM, V3 verifies she works as a Certified Nurse Assistant on night shift at the facility. V3 states she is a loud person and maybe someone has misinterpreted her but denies any allegations of abuse. V3 states she was notified of an allegation of abuse made against her on 5/27/21 by V2 (Director of Nursing) and suspended pending investigation outcome. V3 verifies she has been trained in abuse.

On 5/27/21 at 8:48 AM, V2 states V3 is the only Certified Nurse Assistant working at the facility that has that first name, and verifies she works night shift. V2 states she has received no allegations of abuse against V3. V2 was notified of the allegations made, in which she states V3 will be suspended and an investigation initiated.

On 6/1/21 at 10:15 AM, V1 confirms V3 is the only employee in the facility with that first name.

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S9999	Continued From page 11 V1 states he has received no allegations of abuse or complaints regarding V3, but confirms an investigation is currently being conducted due to the allegations made and conveyed during this survey with the final investigative results still pending. On 6/2/21 at 9:50 AM, V1 states during his investigation he has substantiated verbal abuse occurred by V3 against R4 and R5, as well as R6, expressing feelings of intimidation by V3. V1 states V3 was terminated from the facility on 6/1/21 at 10:00 AM. A facility policy titled "Staff Obligations to Prevent & Report Abuse, Neglect & Theft Acknowledgement". with a revision date of 2/16/11. states, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish." The same policy goes on to state that, "Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." The facility's final Incident Report of Abuse. dated 6/2/21 as reported by V1. documents R4, R5, and R6 were investigated for abuse by V3. The Detailed Incident Summary documents in part, "It was reported by three residents that they feel intimidated by V3 and not turn on their call lights while she is here because of her poor attitude.	S9999		

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S9999	Continued From page 12 One resident reported V3 turns off her call light, leaves her room without providing care. One other resident reported that V3 told her, 'I am tired of this crap and am about done with it all.' One resident reported by one resident that V3 stated, 'I will just turn your O2 (oxygen) off if you don't calm down.' Resident stated she thinks V3 was joking, but she did not appreciate the comment and does not feel safe with V3. During facility and IDPH surveyor investigation mental and verbal abuse was founded in the remarks made by V3,CNA to numerous different residents resulting in residents being intimidated, not feeling safe, and not believing V3 to provide the proper care that is required. As a result V3's employment was terminated on 6/1/21." (B)	S9999		