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
	IL6007389	A. BUILDING: ______ B. WING ______	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIATT COUNTY NURSING HOME	**1111 N STATE ST MONTICELLO, IL 61856**

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S 000	Initial Comments Annual Health Survey Investigation of Facility Reported Incident of 3/12/24/IL171166	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)8) 300.3240a) 300.3240b) 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	S9999		

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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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

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)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

These requirements were not met as evidenced by:

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S9999	Continued From page 2 Based on observation, interview, and record review the facility failed to ensure the right to be free from physical and verbal abuse by staff. R45, who resides on the dementia unit, was subjected to physical and verbal abuse on three separate occasions by V13 Certified Nurse's Assistant and failed to report repetitive instances of verbal and physical abuse of a resident (R45) by V13 Certified Nurse's Assistant and failed to report a resident to resident physical altercation to the facility's Administrator. These failures resulted in V13 having continued access to R45 in which V13 provided direct cares and in the further instances of verbal and physical abuse of R45 by V13. As a result of this abuse R45's hands and chest were bruised and R45 displayed emotional symptoms of residual harm as evidenced by flinching (making sudden startled movements) and increased behaviors with cares. These failures affected three (R45, R35, and R69) of six residents reviewed for abuse on the sample list of 47. This failure has the potential to affect all 24 residents (R66, R77, R70, R3, R47, R55, R20, R74, R9, R59, R76, R45, R62, R79, R19, R8, R35, R10, R69, R61, R5, R65, R36, and R32) residing on the Dementia unit. Findings include: 1. R45's careplan dated 8/24/20 documents R45 has a diagnosis of Dementia with behavioral disturbance, Anxiety, and Chronic pain. This care plan documents R45 has a history of becoming combative with cares and has care planned interventions to stop care and re-approach when combative. On 4/3/24, R45's right hand had faded bruising between the pointer finger and thumb.	S9999		

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The facility's Allegation/Summary conclusion dated 3/19/24 documents on 3/13/24 at approximately 1:45 PM during a team meeting, V16 CNA (Certified Nurse's Assistant) made the comment to the group that V13, CNA was "mean to (R45)" and suggested that a bruise seen on (R45's) hand was from "Where (V13) was holding her down". V7, CNA then added she witnessed an incident the week prior where V13 threatened R45 after R45 became aggressive during care."

V16's Employee Termination Form dated 3/19/24 documents V13 was terminated on 3/13/24. This form documents that V16 verbally and physically abused R45 on 3/6/24 and physically abused R45 on 3/13/24 in which R45 was bruised.

On 4/3/24 at 8:37 AM, V9 CNA stated V13's tone was very aggressive with the residents. A couple months ago, on 1/9/24, I was giving R45 a shower. R45 was becoming combative so I asked V13 for help. R45 made a noise and then said, "oh poo." V9 stated V13 then got in R45's face and meanly said, "Oh Poo!" back to R45 and then "hissed like a snake" in R45's face very aggressively. V9 stated V9 did not report the abuse to V1 Administrator. V9 stated this occurred on 1/9/24.

On 4/2/24 at 3:21 PM, V7 CNA stated on 3/6/24 at 5:30 PM, V13 CNA and I went into R45's room. V7 stated they were transferring her to bed and changing her. V7 stated they were talking to R45 and we were trying to get R45's shirt off but it wasn't working and she was tensed up. V7 stated V13 then tried to force her to take the shirt off without saying anything. V7 stated this caused R45 to try to fight her and R45 began to punch and scratch V13. V7 stated V13 then grabbed both of R45's wrists and pinned them

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against her chest and got face to face to R45 and was touching nose to nose and said, "I will snap your wrists if you wont's let us get you to bed. I will snap your legs." V7 stated they then hooked her up to the mechanical lift and got R45 in the bed. V7 stated V7 took R45's pants off. V7 stated as they were trying to change R45, V13 kept pinning R45's arms to her chest. V7 stated once they were done V13 took a blanket and threw it on her (R45). V7 stated V7 did not report the abuse to V1 Administrator because she was scared of V13.

On 4/3/24 at 8:33 AM, V7 CNA stated after the 3/6/24 incident with V13, R45 was scared. V7 stated during the incident R45 appeared scared, her eyes were great big. V7 stated after that, during cares R45 would flinch (making sudden startled movements) and she still does. V7 stated, "I really feel like she still remembers and is now more combative."

V16's undated witness statement documents on 3/12/23, V16 CNA witnessed V13 physically abuse R45. R45 was hitting at V16's face and V13 then pinned R45's arms to her chest and said stop hitting or I will break your arms. This statement documents V16 was afraid to say anything about the abuse V16 witnessed.

On 4/3/24 at 12:00 PM, V1 Administrator stated V1 was not aware of the verbal and physical abuse of R45 by V13 that occurred on 1/9/24, 3/6/24, and 3/12/24 because the CNAs who witnessed the abuse did not report the abuse to him. V1 stated the abuse did occur and R45 was bruised as a result.

The facility's staffing sheets document V13 worked on the Dementia unit on which R45

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resides on 1/9/24, 1/10/24, 1/15/24, 1/16/24, 1/18/24, 1/20/24, 1/21/24, 1/24/24, 1/30/24, 2/3/24, 2/4/24, 2/6/24, 2/7/24, 2/12/24, 2/13/24, 2/17/24, 2/21/24, 2/26/24, 2/27/24, 3/2/24, 3/3/24, 3/5/24, 3/6/24, 3/11/24, and 3/12/24 (24 shifts after the first instance of abuse occurred on 1/9/24).

On 4/3/24 at 10:30 AM, V26 Administrative Assistant stated V13 works mostly on the Dementia unit and can provide care to all residents on this unit.

The facility's census sheet dated 4/1/24 documents R66, R77, R70, R3, R47, R55, R20, R74, R9, R59, R76, R45, R62, R79, R19, R8, R35, R10, R69, R61, R5, R65, R36, and R32 reside on the Dementia unit.

On 4/3/24 at 12:00 PM, V1 Administrator stated V13 was terminated for the physical and verbal abuse of V13. V1 stated V13 did have bruising as a result of this abuse.

2. On 4/01/24 at 9:30 AM, R35 stated someone bent her thumb back. R35's left thumb appeared a little bigger then the other.

The facility's Abuse Report dated 4/5/24 documents V1 Administrator was made aware of an allegation of abuse on 4/1/24. This report documents upon investigation, R35 and R69 did have a physical altercation on the evening of 3/31/24. This report documents that the on-call nurse was notified but not V1, Administrator.

On 4/4/24 at 9:41 AM, V1 Administrator stated there was an altercation between R35 and her room mate. V1 stated V1 was not immediately notified of the incident.

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S9999	Continued From page 6 The facility's Abuse Prohibition policy dated 8/22/16 documents all residents have the right to be free from verbal and physical abuse. This policy also documents that, "A facility employee or agent who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility administrator." (A)	S9999		