STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005417	A. BUILDING: _____ B. WING _____	C 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHAB & HLTH C CTR	405 WEST CARPENTER MCLEANSBORO, IL 62859

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S 000	Initial Comments FRI of 4/14/2024/IL172588	S 000		
S9999	Final Observations Statement of Licensure Findings 300.610a) 300.1210b) 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		

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These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to ensure residents are free from staff to resident abuse for one of three residents (R1) reviewed for abuse in the sample of 3. This failure resulted in R1 experiencing burning pain and irritation as a result of hand sanitizer being applied to her bottom and legs, some areas of which had excoriation. A reasonable person would also experience feelings of intimidation, fear, emotional distress, and helplessness as a result.

Findings include:

R1's face Sheet documented an admission date of 6/23/2017, and diagnoses including Alzheimer's Disease, Dementia, Chronic Pain, Excoriation (skin picking) Disorder, Anxiety, Hypertension, Gastroesophageal Reflux Disease (GERD), and Osteoporosis.

R1's Minimum Data Set dated for 4/17/2024, documents that R1 has a Brief Interview for Mental Status (BIMS) score of 2, indicating that R1 has severe cognitive impairment . The same MDS documents that R1 is totally dependent on at least two persons assist for transfers, bed mobility, dressing, eating, and toileting needs.

On 5/1/2024 at 9:40am, attempted interview with R1 but due to severe cognitive impairment, R1 was unable to answer questions appropriately.

On 5/1/2024 at 10:26am, V1 (Administrator) stated she was notified on 4/14/2024 at approximately 9:00am by V3 (Licensed Practical Nurse/ LPN) about an allegation of abuse. The

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allegation of abuse involved staff V11 (Certified Nurse's Assistant/ CNA) to R1. V1 stated through the investigation process, it was discovered the actual incident occurred on 4/10/2024 during the evening/night shift. V1 stated V11 reported to her during the investigation, that V11 used Shear Prep Pads which is a barrier/adhesive skin prep used for a prepping the skin prior to applying tape, on R1's bottom and legs to stop her from scratching. V1 stated "Shear Prep pads are 2"x 2" in size are kept locked up by the nurses and it would take a million of these to perform peri care." V1 stated, during the investigation her interviews with other CNA's revealed that V11 told them he applied hand sanitizer to R1's coccyx and legs to stop her from scratching.

On 5/1/2024 at 1:18pm, V8 (Certified Nurse Assistant/ CNA) stated that V7 (CNA) told her that V7 and V11 were caring for R1 when V11 put hand sanitizer on R1's open areas where R1 scratches. V8 stated she was not sure when this happened, she has never seen abuse, but she knows to report it immediately to V1 (Administrator). V8 stated she did not report to anyone at the time she was told about the incident.

On 5/1/2024 2:32pm, V3 (Licensed Practical Nurse/LPN) stated she had abuse reported to her on 4/13/2024 by V4 (CNA). V3 stated V4 told her that V11 threatened R1 to stop scratching and then put hand sanitizer on her scratched areas. V3 stated she instructed V4 to report to V1 immediately. V3 stated she worked the next day and V1 came to the facility and V3 did a head-to-toe assessment on R1. V3 stated the assessment didn't reveal any new issues as R1 always has a red bottom with scratches. R1 did not show any signs of abuse.

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On 5/1/2024 2:10pm, V10 (family member) stated she was notified by V1 of the incident that involved R1 on 4/14/2024. V10 stated she has not seen any change in V10 since the reported incident. V10 stated R1 has had issues with her skin and scratching for many years and she has seen many doctors to find out what the cause is but the doctors, including dermatologist, do not know what the cause is. V10 stated after the investigation it seems as though the incident did occur, but she wasn't for sure. V10 stated she is surprised because she knew V11, but if he would treat anyone in this way then he doesn't need to work around residents. V10 stated she feels like R1 is safe here in the facility.

On 5/1/2024 11:38am, V7 (CNA) stated she didn't report the abuse of R1 herself because she has issues at home with DCFS (Department of Children and Family Services) so she told V8 (CNA), who then told V4 (CNA), who was supposed to tell the LPN (Licensed Practical Nurse). V7 said she is unsure of who the LPN was that was told and is not sure if she was notified. V7 stated she was aware abuse is to be reported immediately but was afraid to do it herself. V7 stated she knows to report to V1 immediately.

ON 5/1/2024 at 9:40am, R1 was observed receiving peri care per V4 (CNA) and V6 (CNA). R1 noted to have multiple scratch marks to her peri area, buttocks, and upper thighs, with many areas open with small amount of blood noted.

The Abuse Investigation's provided by the facility were reviewed. A document titled "Incident Investigation Form" contained a phone interview with V11 dated 4/17/2024 at 1:47pm, and

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documented by V1, stating "the resident was cleaned with sheer prep." V11 was asked if he had anything else to state add and V11 said, "no I don't." The document was signed by V11. An undated and untimed document titled "Incident Investigation Form" documents that the "Person Conducting Investigation" as V1 and the person being interviewed as V7 (CNA). The form had a statement signed by V7 that states "one night me (V7) and V11 was working together. After we did 1am bed checks, he (V11) put hand sanitizer on (R1's) legs because he (V11) thought it would be funny. I (V7) asked him why he (V11) did it and he (V11) just smiled. I (V7) didn't go into the room to check her, so I (V7) didn't see the incident happen." An "Incident Investigation Form" dated 4/14/2024 at 2:00pm, with an interview conducted by V1 with R1 documents "Resident (R1) was asked by the investigator if she remembered ever being cleaned up and it burning? Resident (R1) stated, 'yeah it burnt like fire, I don't know why he done that.' Resident (R1) then rubbed upper thigh." This document signed by V1 and witnessed by V6 (CNA). An "Incident Investigation Form" with an interview conducted by V1 with V3 (LPN) document "CNA (V4) reported to me that CNA (V8) had told her about (V11) abusing (R1). I (V3) asked what happened and (V8) told (V4) she was told that he (V11) was threatening (R1) with hand sanitizer if she (R1) would not stop itching so he (V11) rubbed hand sanitizer on her (R1) wounds on her (R1) coccyx. I (V3) told (V4) that is abuse and they need to report it asap to (V1) and or (V2-Director of Nursing). Nothing can be done unless it is reported." This document has no date or time on it but is signed by V3.

The facility policy titled "Abuse Prevention Program", dated 11/28/2016, documents, "This

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S9999	Continued From page 5 facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within control to prevent occurrences of mistreatment, exploitation, neglect, or abuse of our resident."	S9999		