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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of 12/17/16/IL90639 A partial extended survey was conducted.	F 000		
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to protect a resident (R1) from further abuse after a staff member witnessed and reported verbal abuse. This failure resulted in the staff perpetrator being left with R1 and spraying R1 in the face with water and handling R1 roughly when putting R1 to bed. R1 verbalized being afraid of the alleged perpetrator and requested no further contact. The facility allowed the alleged staff perpetrator continued access to R1 for seven days. R1 is one of three residents reviewed for abuse in the sample of three.	F 223		1/11/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/20/2017

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This failure resulted in an Immediate Jeopardy.

While the immediacy was removed on 01/06/17, the facility remains out of compliance at severity level two. The facility is in the process of evaluating the effectiveness of staff retraining and monitoring the effectiveness of the revised Abuse Prevention policy and it's implementation.

Findings include:

The Physician Order Sheet (POS) dated December 2016 includes the following diagnoses for R1: Parkinson's Disease and Dementia.

The Minimum Data Set (MDS) dated September 30, 2016 for R1 documents R1 as being cognitively impaired. The same MDS documents R1 as needing two people for assistance with transfers and bathing.

On 12/28/16 at 1:58 pm, E7 Licensed Practical Nurse and Charge Nurse stated on 12/17/16 between 6:30 and 7:30 pm, E10, Certified Nursing Assistant (CNA) came to E7 with the abuse allegation that E3, CNA had told E10 in the presence of R1, "I f***ing hate (R1)." E7 stated this incident happened in the shower room. E7 stated that E10 was told to go and report this to E2, Abuse Coordinator. E10 returned later to E7 and reported that E3 had subsequently sprayed water in R1's face with the sprayer and did not give (R1) any notice. E7 stated that E10 was told to report this to E2 also. E7 stated when E7 was

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passing medications to R1 E7 talked to R1 and R1 told E7 that R1 did not feel safe...."(R1) told me (R1) felt unsafe due to the incident in the shower room. (R1) had a funny, scared look on (R1's) face. I did not do a physical assessment, (R1) did not appear hurt, (R1) was emotionally upset. I reported this directly to (E2)."

E7, LPN and Primary Nurse for R1, stated on 12/28/16 at 2:40 pm that R1 is confused at times but "(R1) is able to tell you what is going on for the most part." E7 stated "(R1) and I have a good relationship and (R1) talks to me all the time."

On 12/27/16 at 1:30 pm R1 was sitting in R1's room watching television and stated R1 did not want to talk about R1's care in the facility.

On 12/28/16 at 11:00 am R1 was sitting in the hallway and volunteered "there was a CNA that was mean to me in the shower." R1 refused to talk about it any further.

On 12/28/16 at 2:40 pm, E7 acknowledged that on 12/17/16 E3 was still in the shower room (alone) with R1 after E10 reported the alleged verbal abuse. E7 stated "I didn't think, but I should have got (E3) away from (R1). I screwed up." E7 acknowledged that E3 was left alone with R1 while E10 reported the verbal allegation to E2. E7 stated E10 returned to the floor and went back to the shower room where R1 was still with E3. E7 stated "this is when (E10) came back out and reported that (E3) had sprayed (R1) in the face."

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E7 stated E7 was not positive of the time, but thought around 6:30 to 7:30 pm. E7 acknowledged that E2 had not yet come to the unit and E7 did not remove E3 from the care area. E7 stated E3 was sent home around 9:30 pm (12/17/16 approximately 1.5 to 2.0 hours later) after E2 came to the floor around 9:15 pm.

A facility report titled "Employee Daily Activity Report" printed 12/29/16 confirms that E3 clocked out at 9:29 pm on 12/17/16.

On 12/28/16 at 12:30 pm, E10 stated that on 12/17/16 E10 heard E3 say "I f****ing hate (R1)" while transferring R1 into the shower chair. E10 stated that E10 left the shower room and reported this to E7. E10 stated E7 told E10 to report the allegation to E2. E10 stated E10 left the unit and reported the incident to E2 at around 8:00 pm. E10 stated " I told (E2) exactly what (E3) said and what I heard." E10 stated "(E2) kind of blew me off." E10 stated E10 then returned to the unit and went back to the shower room to check on R1, who remained alone with E3. E10 stated that E3 had shaved R1 and then took the sprayer and sprayed R1 in the face with the sprayer and it scared R1. "(E3) didn't explain anything to (R1), (E3) did it on purpose." E10 stated this too was reported to E7 and was told to let E2 know about this.

At 4:20 pm on 12/28/16, E10 stated that on 12/17/16 E10 followed E3 with R1 to R1's room to help transfer and put R1 to bed. E10 stated that E3 was very rough and was jerking R1 and rolled him forward fast toward E10. E10 stated R1 was

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upset and had a funny, scared look on R1's face. E10 stated "(E3) gets frustrated easily." E10 stated that E2 came to the unit at approximately 9:15 pm. E10 confirmed again E10 was positive that E10 heard E3 say "I f****ing hate (R1)" and witnessed E3 spray R1 in the face with the sprayer. E10 stated again "(E3) was rough and jerking (R1) when putting (R1) to bed, yes I thought this was wrong." E10 stated "I did not see how (E3) dried (R1) off, that could have happened when I went to report to (E2)." E10 stated "I reported all to (E2) what I heard and saw. I should have made sure (E3) was not left with (R1)."

On 12/28/16 at 3:40 pm E3 stated that on 12/17/16 "(E3) was frustrated with the situation not with (R1)." E3 confirmed that E10 had helped E3 in the shower with R1 and had helped put R1 to bed. E3 stated "(E10) could have misconstrued the tone of my voice as being toward (R1)....I can't say what (E10's) perception was."

A facility report titled "Employee Daily Activity Report" printed 12/29/16 documents E3 working the following days in the facility following the 12/17/16 incidents as a direct care giver for all residents in the facility: 12/17/16 - 7.0 hours (punched out at 9:29 pm), 12/18/16 - 7.5 hours, 12/19/16 - 5.25 hours, 12/22/16 - 7.75 hours, 12/23/16 - 7.5 hours, 12/26/16 - 7.5 hours, 12/27/16 - 8.0 hours and 12/28/16 - 3.75 hours.

On 12/28/16 at 12:50 pm, E2 confirmed that E10 did report the allegations of verbal abuse and of

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E3 spraying R1 in the face and putting R1 to bed roughly. E2 stated "I didn't believe (E10), (E3) is a good CNA." E2 acknowledged that E3 had access to R1 after E10's initial allegation on 12/17/16 and on subsequent scheduled days working as a direct care giver.

On 12/29/16 at 9:30 am E2 acknowledged that E2 did not go to the unit when E10 reported the verbal abuse on 12/17/16.

On 12/29/16 at 10:30 am, E14 Executive Assistant to E2 stated that E3's employment had been terminated.

An Immediate Jeopardy was identified on 01/06/17. The Immediate Jeopardy began on 12/17/16, when R1 was mentally, verbally and physically abused by E3 and facility action was not immediately taken to protect R1 from further abuse.

On 01/06/17 at 9:00 am, E2 was notified of the Immediate Jeopardy.

The surveyor was able to confirm through interviews and record review the following facility actions:

1. The alleged perpetrator's (E3) employment was terminated, effective 12/28/16. Completed by E2, Abuse Prohibition Coordinator.

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F 223	Continued From page 6 2. Education Inservices implemented by Z2, Licensed Clinical Social Worker on protection of the resident during an abuse allegation, reporting the abuse allegation(s) to the Administrator and thoroughly investigating the alleged abuse allegations was completed on 1-6-17. All scheduled employees were required to complete this mandatory training prior to beginning their shift. 3. The facility's Abuse Prevention policy was revised to ensure resident protection (removal of the alleged perpetrator) when potential abuse has been identified and immediately reporting the allegation to the Administrator. Completed by facility legal counsel on 1-6-17.	F 223		
F 225 SS=L	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 225		1/11/17

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body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the

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administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to thoroughly investigate allegations of employee abuse toward R1 and failed to protect R1 from further abuse even after R1 expressed fear and requested no contact with the alleged perpetrator. The facility failed to report three additional allegations of verbal/mental and physical abuse toward R1 by the same alleged perpetrator to the State Survey Agency. These failures resulted in the alleged perpetrator having continued access to R1 for approximately two hours and seven subsequent working days. R1 is one of three residents reviewed for abuse in the sample of three. These failures resulted in the alleged perpetrator having continued access to R1 and 39 other residents in the facility, for approximately 2 hours and seven subsequent working days, putting them all at risk for abuse.

These failures resulted in an Immediate Jeopardy.

While the immediacy was removed on 01/06/17, the facility remains out of compliance at severity level two. The facility is in the process of evaluating the effectiveness of staff retraining and monitoring the effectiveness of the revised Abuse Prevention policy and it's implementation.

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Findings include:

R1's Physician Order Sheet documents diagnoses of Parkinson's Disease and Dementia. R1's Minimum Data Sheet documents that R1 as being cognitively impaired and needing the assist of two for transfers and bathing.

On 12/28/16 at 12:30 pm, E10 Certified Nursing Assistant (CNA) stated that on 12/17/16, E10 assisted E3, CNA in giving R1 a shower. E10 stated that while transferring R1 into the shower chair E3 stated "I f****ing hate(R1)." E10 stated R1 heard E3 and "I heard (E3) say it." E10 stated this was reported to E7, Licensed Practical Nurse and E7 told E10 to report the allegation to E2, Abuse Coordinator. E10 stated E10 went to E2 at approximately 8:00 pm and reported the allegation of verbal/mental abuse to E2. E10 acknowledged that R1 was left alone with E3 while reporting to E2. E10 stated when E10 arrived back on the unit E3 was still in the shower room alone with R1 and E10 went in to check on them. E10 stated E10 witnessed E3 spray R1 in the face with the water sprayer without any notice to R1. E10 stated R1 was startled. E10 stated E3 and E10 then took R1 back to R1's room. E3 proceeded to put R1 to bed. E10 stated that E3 was jerking and being rough with R1. E10 stated E10 left the room and reported this to E7 and was again directed to tell E2. E7 did not intervene to protect R1 from E3 at any time.

On 12/28/16 at 1:58 pm, E7 acknowledged that on 12/17/16, E10 did report that E3 had told E10

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that E10 "f****ing hated (R1)" and E7 had directed E10 to report this to E2. E7 acknowledged that E7 should have removed E3 from the shower room. E7 stated "I screwed up." E7 acknowledged that E10 also reported E3 spraying water in R1's face and E3 being rough by jerking R1 around in the bed. E7 stated E7 passed medications to R1 and R1 told E7 that R1 felt unsafe with E3 and had a scared look on R1's face. E7 stated this also was reported to E2 when E2 arrived on the unit at approximately 9:15 pm to speak with E3.

Included in the facility abuse /incident files was a report titled "Initial Report" to the Illinois Department of Public Health dated 12/17/16 that documented the following: "concern for potential abuse." The report documents that an allegation of abuse was given to E2 by R1 of concerns regarding how a Certified Nursing Assistant (E3) treated R1 during a shower and that an investigation was underway.

There were no other abuse allegations or investigations in the facility files documenting E10 reporting the allegations of verbal/mental and subsequent physical abuse to R1. The abuse interviews for the 12/17/16 allegation are incomplete. There is no documentation of what residents or employees were interviewed on in correlation to the allegations. The roughness of towels and shower care are documented in the interviews.

A facility report titled "Final Report" dated 12/20/16 transmitted by facsimile to the Illinois

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Department of Public Heath documents the following: "On December 17,2016, the resident (R1) communicated to the charge nurse that (R1) was concerned about the way (R1) was treated during the course of (R1's) shower. The family and resident physician were notified immediately. (E2), Abuse Coordinator Designee, called the CNA (E3, Certified Nursing Assistant) into the office and the situation was explained to (E3). (E3) was told that interviews would be conducted and a meeting would be held the next day to inform (E3) of the results of the investigation. The CNA (E3) was sent home at 9:30 pm.....(E2) interviewed the resident immediately following the incident. The resident (R1) stated that during the course of the shower, the CNA (E3) dried (R1) off, (E3) was extremely brisk and (E3) threw the towel, seeming to be very impatient. When questioned about whether (R1) felt unsafe, the resident (R1) stated that (R1) felt safe, although (R1) preferred that (R1) was not showered by this CNA (E3) again. The resident (R1) further stated that (R1) would prefer that nobody knew about the incident.....On December 18, 2016, the CNA (E3) was counseled by (E2). The resident's (R1) degenerative joint disease was explained to (E3) and how the disease affects the resident's (R1) motor control. The CNA (E3) was advised that (E3) needed to slow down and take (E3's) time when dealing with residents in this type of situation. It was also emphasized to (E3) that gentleness was absolutely essential when dealing with the elderly due to muscles and joints that don't respond as readily and skin that is much more fragile. SUMMARY: Following interviews with the involved parties, the resident's daughter and a medical record review, no evidence of abuse could be found. The incident was the result of a staff member (E3) who did not fully

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understand the resident's medical issues and it's ramifications and tried to hurry the process. No deliberate attempt to harm could be documented." Signed by E1, Interim Administrator, with E2, Temporary Administrator (Abuse Coordinator Designee) and E13, Director of Nursing typewritten names.

E11, CNA stated on 12/28/16 at 2:30 pm that E11 was also on duty the evening of 12/17/16. E11 stated that E2, Abuse Coordinator never came and interviewed E11 as a potential witness about R1 or E3 as part of an abuse investigation.

A facility report titled "Employee Daily Activity Report" printed 12/29/16 documents E3 working the following days in the facility following the 12/17/16 incidents as a direct care giver for all residents in the facility: 12/17/16 - 7.0 hours (punched out at 9:29 pm), 12/18/16 - 7.5 hours, 12/19/16 - 5.25 hours, 12/22/16 - 7.75 hours, 12/23/16 - 7.5 hours, 12/26/16 - 7.5 hours, 12/27/16 - 8.0 hours and 12/28/16 - 3.75 hours.

On 12/28/16 at 12:50 pm, E2 confirmed that E10 did report the allegations of verbal abuse and of E3 spraying R1 in the face and putting R1 to bed roughly. E2 stated "I didn't believe (E10), (E3) is a good CNA." E2 acknowledged that E3 had access to R1 after the initial allegation made by E10 on 12/17/16 and on seven scheduled days after that as a direct care giver.

On 12/29/16 at 10:40 am, E2 acknowledged that E2 did not document the allegations made by E10

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ARTHUR HOME, THE	**423 EBERHARDT DRIVE ARTHUR, IL 61911**

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(verbal abuse allegation, mental abuse allegation and physical abuse allegation) and did not do a thorough investigation. E2 acknowledged that the only allegation that E2 reported to the State agency was what R1 reported to E2 in an interview about E3 being rough with the towels in the shower. E2 acknowledged that E2 should have removed E3 from the care area when E10 first reported the allegation of abuse. E2 stated "I should have went immediately to the unit, I failed to do that." E2 acknowledged that had E2 went immediately to the unit, further abuse to R1 could have been prevented.

An Immediate Jeopardy was identified on 01/06/17. The Immediate Jeopardy began on 12/17/16, when R1 was mentally, verbally and physically abused by E3 and facility action was not immediately taken to protect R1 from further abuse.

On 01/06/17 at 9:00 am, E2 was notified of the Immediate Jeopardy.

The surveyor was able to confirm through interviews with staff and record review that the facility had started the following:

The surveyor was able to confirm through interviews and record review the following facility actions:

1. The alleged perpetrator's (E3) employment was terminated, effective 12/28/16. Completed by E2, Abuse Prohibition Coordinator.

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F 225	Continued From page 14 2. Education Inservices implemented by Z2, Licensed Clinical Social Worker on protection of the resident during an abuse allegation, reporting the abuse allegation(s) to the Administrator and thoroughly investigating the alleged abuse allegations was completed on 1-6-17. All scheduled employees were required to complete this mandatory training prior to beginning their shift. 3. The facility's Abuse Prevention policy was revised to ensure resident protection (removal of the alleged perpetrator) when potential abuse has been identified and immediately reporting the allegation to the Administrator. Completed by facility legal counsel on 1-6-17.	F 225		
F 226 SS=L	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95	F 226		1/11/17

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F 226	Continued From page 15 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop and implement an abuse prevention policy that included procedures to ensure that all abuse allegations are investigated thoroughly. The facility failed to operationalize their current Abuse Prevention policy, resulting in R1 being left unprotected after a witnessed and reported verbal/mental abuse allegation. R1 verbalized that R1 was afraid of the alleged perpetrator and was then subjected to subsequent physical abuse by the same perpetrator. R1 is one of three residents reviewed for abuse in the sample of three. These failures resulted in the alleged perpetrator having continued access to R1 and 39 other residents in the facility, for approximately 2 hours and seven subsequent working days, putting them all at risk for abuse.	F 226		

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This failure resulted in an Immediate Jeopardy.

While the immediacy was removed on 01/06/17, the facility remains out of compliance at severity level two. The facility is in the process of evaluating the effectiveness of staff retraining and monitoring the effectiveness of the revised Abuse Prevention policy and it's implementation.

The facility policy titled "Abuse Policy" dated December 2016 directs staff on the following: "All employees, residents, and families of (the facility) must immediately report any incident or suspected incident of resident abuse, neglect, or misappropriations of resident property to the Abuse Prevention Coordinator. The Abuse Prevention Coordinator will notify the Director of Nursing immediately.....All staff are instructed to inform the Administrator, as the facility's Abuse Prevention Coordinator, of any allegation of resident abuse.....If resident abuse is suspected, a licensed nurse will examine the resident for signs of injury and notify the Administrator, Director of Nursing, resident Physician, and resident's family.....Any employee who knows or suspects that the abuse has occurred and has not reported the abuse or makes false allegations of abuse will face possible termination. Once the investigation is complete, the Administrator will consult with the Director of Nursing and/or the Assistant Director of Nursing to determine the conclusion of the investigation and any disciplinary action necessary....When an employee is alleged to have committed abuse of any kind, that employee shall be immediately suspended without pay from employment at the facility, not having any further resident contact,

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pending the outcome of the investigation.....An initial report will immediately be made of all alleged incidents to the state agency and any other agencies as required. A follow up report will also be made to the state agency, and any other agencies as required, at the conclusion of the facility's investigation which must be within 5 days....."

The facility Abuse Policy as referenced above does not document or outline detailed procedures of any kind for staff to follow with regard to conducting, completing and concluding an abuse investigation.

On 12/28/16 at 4:20 pm, E10, Certified Nursing Assistant (CNA) stated E10 was told by another CNA, E3 while giving R1 a shower on 12/17/16, that E3 stated "I f***ing hate (R1)." E10 stated E10 reported this incident to E7, Licensed Practical Nurse and was told to go tell E2, Abuse Coordinator. E10 stated it was reported to E2 at approximately 8:00 pm. E10 stated on return to the floor E3 was still in the shower room alone with R1. E10 joined E3 in the shower room and witnessed E3 spray water in R1's face after shaving R1 and did not tell R1 what E3 was doing. E10 stated this too was reported to E7. E10 stated E10 was directed to tell E2 whenever E2 got to the unit. E10 stated E3 then left the shower room with R1 and E10 helped E3 put R1 to bed. E10 stated E3 was rough and was jerking R1 around in the bed. E10 stated at approximately 9:15 pm E2 came to the unit and the additional two allegations of mental and physical abuse were reported. E10 stated E2 removed E3 at this time and believes E3 went

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home around 9:30 pm.

The facility abuse investigation files do not document any of the above allegations made by E10 concerning E3 and R1. An abuse investigation file dated 12/17/16 documents that R1 reported that a CNA (E3) was rough with R1 while drying R1 off in the shower. The investigation that E2 conducted includes names of residents and employees that were interviewed about showers. The content of the interviews were not documented. In the 12/17/16 abuse investigation file there is documentation of a facility ancillary order for new "softer" towels.

On 12/29/16 at 10:40 am, E2 acknowledged that E2 concluded at the end of E2's investigation E3 had hurried R1 during R1's shower and the roughness of the towels used, were contributing factors in R1's perception of E3 being rough with R1 in the shower. E2 acknowledged that E10 did report the allegations of E3 stating "I f***ing hate (R1)" and E3 spraying water in R1's face and being rough with R1 in the bed. E2 acknowledged that neither of these allegations are documented in an investigation report nor were they investigated and reported to the State Survey agency. E2 acknowledged that E3 was not removed from the resident care area until 9:30 pm on 12/17/16 and returned to E3's regularly scheduled shift the next day on 12/18/16.

On 12/28/16 at 12:50 pm, E2 acknowledged again that E10 did report the allegations of verbal abuse and of E3 spraying R1 in the face and

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putting R1 to bed roughly. E2 stated "I didn't believe (E10), (E3) is a good CNA." E2 acknowledged that E3 had access to R1 after the initial allegation made by E10 on 12/17/16 and on seven scheduled days after that as a direct care giver.

A facility report titled "Employee Daily Activity Report" printed 12/29/16 documents E3 working the following days in the facility following the 12/17/16 incidents as a direct care giver for all residents in the facility: 12/17/16 - 7.0 hours (punched out at 9:29 pm), 12/18/16 - 7.5 hours, 12/19/16 - 5.25 hours, 12/22/16 - 7.75 hours, 12/23/16 - 7.5 hours, 12/26/16 - 7.5 hours, 12/27/16 - 8.0 hours and 12/28/16 - 3.75 hours.

An Immediate Jeopardy was identified on 01/06/17. The Immediate Jeopardy began on 12/17/16, when R1 was mentally, verbally and physically abused by E3 and facility action was not immediately taken to protect R1 from further abuse.

On 01/06/17 at 9:00 am, E2 was notified of the Immediate Jeopardy.

The surveyor was able to confirm through interviews with staff and record review the following had been started:

The surveyor was able to confirm through interviews and record review the following facility actions:

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F 226	Continued From page 20 1. The alleged perpetrator's (E3) employment was terminated, effective 12/28/16. Completed by E2, Abuse Prohibition Coordinator. 2. Education Inservices implemented by Z2, Licensed Clinical Social Worker on protection of the resident during an abuse allegation, reporting the abuse allegation(s) to the Administrator and thoroughly investigating the alleged abuse allegations was completed on 1-6-17. All scheduled employees were required to complete this mandatory training prior to beginning their shift. 3. The facility's Abuse Prevention policy was revised to ensure resident protection (removal of the alleged perpetrator) when potential abuse has been identified and immediately reporting the allegation to the Administrator. Completed by facility legal counsel on 1-6-17.	F 226		