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	IL6001044	A. BUILDING: _____ B. WING _____	02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON CARE CENTER	1201 NORTH ALTON LEBANON, IL 62254

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1220b)2) 300.3240a) 300.3240e) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

Based on interview and record review, the facility failed to prevent abuse and prevent misappropriation of resident's property for two of three residents (R15 and R42) reviewed for abuse in the sample of 32. This failure resulted in R15 being hit by staff and receiving a bruised eye.

Findings include:

1. R15's Minimum Data Set (MDS), dated 8/3/18, documents R15's Brief Interview for Mental Status Score (BIMS) of 2 indicating R15 has severely impaired cognition.

R15's Physician Order Sheet (POS), dated 2/2019, documents R15 has the diagnosis of Dementia.

The Incident Report Form-IDPH Notification, dated 9/5/18, documented "Resident alleged staff

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member hit him when he got him up. Resident assessed and facility initiated an investigation per protocol." The Form documented R15 sustained a bruise.

The Facility's final letter regarding R15's abuse investigation, dated 9/11/18, documents an allegation of physical abuse involving R15 and V15, Certified Nurse's Assistant, CNA. The letter documented "On 9-5-18 at approximately 6:50 AM, staff reported that (R15) had made an allegation that a staff member had hit him. The nurse assessed and noted a red area at the corner of the left eye. The facility initiated investigation per protocol including notification of resident's physician, family and suspension of the employee. The facility notified the local police department. The nurse reported that she approached (R15) about getting dressed for the day. The nurse reports (R15) stated, 'Why did you do that to me? I've never been treated this way?' The nurse noticed a red area at the corner of the resident's eye." The letter documented "During the investigation, V11(CNA), stated that V15 (night shift CNA) had given her report that (R15) had been combative during morning care. According to V11, day shift CNA; V15 (CNA) reported that she had to "f*** him up. V11, reported to the nurse and they contacted the Administrator to report." The letter documented that V15 denied the allegation and denied having physical contact with R15. The letter documented "In conclusion, through investigation, the facility was able to substantiate the allegation and (V15) was terminated."

R15's Nurse's Note, dated 9/5/18 at 6:30 AM documented "I opened the door, the res (resident) (R15) was sitting in his w/c (wheelchair) facing the window. I went et (and) got the res et

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brought him to the sink to see if I could get his clothes on him et the res (R15) started yelling @ (at) me again that he was treated so bad et that he was punched. I kneeled down to talk to him et @ this time I noticed the res left eye was swollen et had a gray color to it so I called the CNA (V11) into the room to see the res (R15) eye. The res cont (continued) to say he was punched in his eye."

The Local Police Department Offense/Incident Report, dated 9/5/18, documented the police officer took a report of aggravated battery of victim over 60. The report documented " V1 (Administrator), advised she observed a black and blue mark under the left eye of (R15). I met with (R15) who was not very talkative. I did observe bruising under his left eye."

On 2/7/19 at 9:05 AM, V11 stated "My shift started at 6:00 AM on 9/5/18. I received report from (V15) around 6:15-6:30 AM, that (R15) did not want to get up that morning but he was up in his chair." V11 stated during this report, she had to assist another resident. She stated when she was done and as V15 was leaving the building, V15 walked by her and said "I had to f*** (R15) up." V11 stated she immediately informed V13, LPN (Licensed Practical Nurse) of what V15 had stated as she was leaving. V11 further stated that she did see the bruise on R15's face near R15's left eye on the morning of 9/5/18. R15 did not have a bruise on his face the day before.

On 2/7/19 at 9:10 AM, V13, LPN, stated, "I came in on day shift 9/5/18 and received report from the night shift nurse around 6:30 AM. It was around 6:45 AM when I noticed that (R15) was in his room naked. I went in to assist (R15) and he did not want me to touch him. He said he was hit. I

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noticed his left eye was red and that is when (V11) entered the room and informed me what (V15) had told her as she was leaving the building. I immediately notified V2, Director of Nursing, (DON) who came down to assess (R15)." V13 further stated that R15, for at least the next 48 hours, was not his usual self as he presented with a hurt "broken" disappointed affect.

On 2/7/19 at 9:15 AM, V12, CNA, stated "I got to (R15's) room around 6:30 AM-6:45 AM on 9/5/18 and at that time (V13) and (V11) were in the room with (R15)." V12 further stated that R15 was in his room, refusing care, sitting in the corner crying, very upset and stating that someone had hit him.

On 2/7/19 at 9:30 AM, V2, (DON) stated, "I was paged around 6:50 AM on 9/5/18 to come back to the Looking Glass Unit right away. I was informed by (V13) that (R15) had stated that 'someone' had hit him and that his left eye was red. I assessed (R15) at that time and (R15) repeatedly stated 'I can't believe someone did this to me. I can't believe someone did this to me.'" V2 stated "It was very sad." V2 further stated that R15 did have discoloration under the left eye. V2 continued that R15, due to his dementia diagnosis ,was unable to state who hit him but "I was able to use simple questions to determine who it was", further stating that "it was a younger, person of color. I notified (V1, Administrator) at that time." V2 stated that V15 had already left the building from the completion of her shift.

On 2/8/19 at 8:30 AM, V1 stated "(V2) contacted me as soon as she assessed (R15) related to the suspected abuse." V1 stated "(V15) was notified on 9/5/18 that she was suspended until the

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allegation of abuse was completed. Once my investigation was completed, I was able to substantiate the abuse allegation and (V15) was terminated on 9/10/18."

2. R42's September POS documents a diagnosis of closed head injury due to motor vehicle accident, chronic pain, hemiplegic, seizure, and depression. R42's POS also documents R42 is to receive oxycodone-acetaminophen 5-325 milligram 1 tablet by mouth twice a day.

R42's MDS dated 06/26/2019 documents a BIMS score of 15 out of 15, indicating no cognitive impairment

On 01/31/2019 at 10:00 AM, R42 stated, "Yes there was a staff member V7 (Licensed Practical Nurse/LPN) a while back that was fired for taking my medication. It was a few months back. (V7) has not been back and no longer works here. She was taking my pain medication."

On 02/08/2019 at 1:08 PM, V6, (LPN) stated, "I was working the night the medicine was missing. I was helping out, passing medications, when I noticed R42 had some white pills on the card that were taped in place, The pills had a different code than the other pills. I immediately notified V3 (Resident Care Coordinator). We found out later that the pills were acetaminophen instead of the oxycodone. When we started checking, there were other medications that were wrong as well."

On 02/08/2019 at 1:40 PM, V1, Administrator stated, "Yes, we terminated (V7) as we felt like (V7) was the only one who could have stolen the drugs from (R42) and we did not suspect anyone else. (V7) had left her shift for the day and she

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never came back into the building and she was terminated. I started an investigation immediately when I found out drugs were missing."

The Follow Up Letter Notification to the State dated 09/21/2019 at 8:18 AM, related to the incident on 9/21/2019 documents the following, "During the medication pass, V6 (Licensed Practical Nurse, LPN), reported a possible misappropriation of resident's medication card. The nurse noted there were 2 tablets that had been taped back in the medication card. The nurse noted that the 2 tablets that were taped in the card were different than the prescribed card. V6, LPN, notified the nurse manager on duty, V3 (Resident Care Coordinator), of the discrepancy. During the investigation V3 was able to confirm the 2 tablets were not the correct medication for the card. It was identified that the 2 tablets taped in the card were acetaminophen. It was noted that R42 did not miss any doses of the prescribed medication. The nurse manager completed an audit of all controlled medications in the facility. It was noted that all controlled medication counts were correct, however there were discrepancies noted with administration times from V7, LPN. In conclusion, after a thorough investigation,including review of staff interviews, the facility was able to substantiate that there were discrepancies during V 7's previous shift, in addition to possible misappropriation of resident's medication. The facility has made a decision to terminate her employment."

R42's Controlled Substance Record documents on 09/12/2018 received 2 doses of oxycodone-acetaminophen on 09/12/2018 at 4PM.

V6's statement dated 09/12/2018 documents, "I

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S9999	Continued From page 7 worked a 10 hour shift, splitting the hallways medication pass. I passed the residents' 4 PM medications. This was to help the nurse scheduled 2PM- 10PM. On 09/13/2018, during my medication pass, I was getting a resident's medication ready to give. This resident gets a narcotic pain medication. When signing the narcotics sheet, I noticed that the nurse that relieved me on 09/12/2018 had signed out a 4PM narcotic pain pill. There was no reason for her to give this medication because I had already given it . V7 was aware of this. When I looked at the narcotic card, I noticed there was tape holding two pills and seen the print on those two pills were different from the other pills in the card. After I seen this, I notified my supervisor. She then went through all of the narcotics in the box and checked all narcotic sheets for any other mistakes. More mistakes were found." On 02/01/2019 at 2:01 PM, V3 stated, "No, we did not suspect any other staff member of taking the pills. V7 had only worked here for a short time and V7 was terminated." On 02/08/2019 at 1:16 PM, V3 stated "Yes, we fired V7 for the drug mix up." (B)	S9999		