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
	IL6002653	A. BUILDING: _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME	9890 STAR LANE, P.O. BOX 317 MACON, IL 62544

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S 000	Initial Comments Complaint Investigation 2068883/IL128553	S 000		
S9999	Final Observations Statement of Licensure Violations Section 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 1) "911" an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and rescue. b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 4) When a crime has been committed in a facility by a person other than a resident; or c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (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 facility administrator. (Section 3-610 of the Act)	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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) These requirements are not met as evidenced by: Based on record review and interview the facility failed to ensure R1 was not subjected to physical abuse by an employee, failed to immediately report an allegation of employee to resident physical abuse, and failed to contact the police regarding physical abuse of a resident for one of nine residents (R1) reviewed for abuse in the sample list of nine. This failure resulted in R1 sustaining a raised, reddened area on the top left (intraoral) palate which had some bleeding. Findings include: The facility's Abuse Prevention policy dated 3/27/17 documents, "Employees are required to report any allegation or suspicion of abuse or neglect they observe, hear about, or suspect to the administrator/designee or direct supervisor who must then immediately report it to the administrator." This policy also documents, "Administrator or designee shall immediately contact local law enforcement authorities for the following situations: Physical abuse involving physical injury on a resident by a staff member or visitor. When a crime has been committed in the facility by a person other that a resident."	S9999		

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The facility's initial faxed report dated 11/6/20 at 10:48 AM documents, "On November 5, 2020 at approximately 8:40 PM, staff notified Administrator of a potential abuse allegation. The staff member was suspended pending investigation. The resident was immediately assessed. Physician and family were notified." This document was signed by V1 (Administrator).

The facility's final investigation report dated 11/9/20 at 2:28 PM documents, (R1) has lived at the facility since April 2015 and has a primary diagnosis of Dementia with Behavioral Disturbances. (R1) is completely dependent on staff for all ADL's (Activities of Daily Living) and requires a full mechanical lift for all transfers. On November 5 around 8:40 PM (V4) a CNA (Certified Nursing Assistant) heard (R1) yelling out, as (R1) normally does, but (V4) stated (R1) sounded different. (V4) entered (R1's) room and found a washcloth in (R1's) mouth. This investigation report also documents after staff interviews and review of the monitoring systems that it was determined (V6) CNA placed the washcloth in (R1's) mouth to muffle the sound of (R1's) yelling out so that (V6) could make a private phone call in (R1's) room. This report is signed by V1.

R1's Minimum Data Set (MDS) dated 10/1/20 documents R1 is severely cognitively impaired and R1 is totally dependent on two staff for transfers and bed mobility. R1's Care Plan dated 4/18/18 documents R1 has limited extension of fingers in both hands. Due to R1's cognitive impairment, R1 could not be interviewed.

On 11/16/20 at 12:14 PM, V1 (Administrator) stated V1 investigated the abuse allegation against (V6) but (V6) would not give V1 a

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statement and would not return any of the facility's telephone calls. V1 stated they determined V6 had placed the washcloth in (R1's) mouth. V1 confirmed V4 did not immediately report the allegation like V4 should have. V1 stated V1 did not call the police. V1 stated V1 did not feel that it was necessary to call the police. V1 stated V1 was not sure that V6 putting the washcloth in R1's mouth met the definition of abuse.

On 11/16/20 at 1:00 PM, V2 (Director of Nursing) stated on 11/5/20 V2 received a call from the charge nurse that there was an issue that V2 needed to handle. V2 stated the nurse (V3) stated a CNA had found a washcloth stuffed in (R1's) mouth. V2 stated V2 immediately called V1 and V2 headed for the facility. V2 confirmed there was a time lapse between when V4 found the washcloth in R1's mouth and when V4 reported it to V3 (Registered Nurse). V2 stated V2 was not aware that the time lapse was as long as it appeared to be. V2 stated V6 was terminated and the facility reported V6 to the Illinois Department of Financial and Professional Regulation. V1 stated V1 does not feel the police needed to be called. V2 stated the facility handled it.

On 11/16/20 at 2:34 PM, V3 (Registered Nurse) stated during the evening shift on 11/5/20 V3 had been on the first floor passing medication and when V3 returned to the second floor V4 and V5 pulled V3 into an empty room and told V3 that they found a washcloth in R1's mouth. V3 stated that V3 called V2 (Director of Nursing) immediately. V3 stated after V3 called V2, V3 went to check on R1. V3 stated R1 appeared to be breathing fine and R1 did not appear to be struggling for air. V3 stated R1's lips were not blue and R1 did not have any mottling of R1's

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extremities. V3 stated when V2 arrived V3 went to the sunroom with V2 and V6. V3 stated when V6 told them V6 did not do that, V6 was moving V6's head back and forth with attitude. V3 stated V3 was shocked that it happened, but V3 stated V3 was not surprised that V6 had put the washcloth in R1's mouth. V3 stated V6 would always disappear into resident's room to talk on V6's phone.

On 11/16/20 at 2:52 PM, V4 stated on 11/5/20 during the evening shift, V4 was assisting V5 (CNA) in giving R7 a bath. V4 stated that V4 had forgotten R7's clothes in the other shower room and then forgot R7's soap. V4 stated that V4 made two separate trips back down the hall to the other shower room. V4 stated during the second trip V4 heard R1 yelling out, but V4 stated it sounded more muffled than usual. V4 stated V4 went into R1's room to check on R1. V4 stated when V4 entered R1's room V4 saw a washcloth stuffed in R1's mouth and that was why R1 sounded muffled. V4 stated V4 could tell that R1 was still breathing and V4 stated V4 did not know what to do. V4 stated V4 looked for the nurse but did not see the nurse. V4 stated V4 went back down to the other shower room where V5 was and told V5 what V4 had found. V4 stated that V4 wanted someone else to see it. V4 stated V5 told V4 to find the nurse. V4 stated V4 went back out on the floor but still could not find the nurse so V4 stated V4 and V5 went back to R1's room and V4 removed the washcloth from R1's mouth. V4 stated that most of the washcloth was stuffed in R1's mouth. V4 stated R1's mouth looked raw and there was a small amount of blood on the washcloth.

V4 stated V4 then raised the head of R1's bed up and made sure R1 looked ok. V4 stated V4 and

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V5 then went back to the shower room to finish helping with R7's bath. V4 stated V4 thought it was around 8:00 PM. V4 stated V4 and V5 took R7 to R7's room and got R7 into bed. V4 stated after that V4 and V5 went to R8's room to try to get R8 to go to bed. V4 stated R8 was not ready to go to bed yet. V4 stated after that they noticed the nurse (V3) was back at the nurse's station. V4 stated they pulled V3 into an empty room and told V3 what they had found. V4 stated that V3 called V2 (Director of Nursing) right then. V4 stated V3 told V4 to stay at the nurse's station and V3 went to the other nurse's station where V6 (CNA) was. V4 stated V6 told V4 that V6 had taken R9 to the bathroom while V4 and V5 were in the empty room with V3. V4 stated V2 arrived pretty quickly after V3 had called V2. V4 stated V2 and V3 took V6 to the sunroom. V4 stated after that V6 walked down to the nurse's station where V4 was and V6 stated V2 and V3 said V6 had stuffed a washcloth down R1's throat. V4 stated V6 then got on the elevator by V6's self and went downstairs and V4 stated they saw V6 get into V6's car and leave.

On 11/16/20 at 3:10 PM, V5 stated on 11/5/20 V5 and V4 were giving R7 a bath. V5 stated V4 went to get something that V4 had forgotten in the other shower room and when V4 came back V4 said V4 needed V5 to see something. V4 took V5 to R1's room. V5 stated (R1) had a washcloth stuffed in (R1's) mouth. V5 stated, "(R1) could've died." V5 stated V5 told V4 that is abuse. V5 stated V5 told V4, V4 needed to find the nurse. V5 stated that most of the washcloth was packed in R1's mouth pretty tight. V5 stated V4 had to really pull on it to get it out of R1's mouth. V5 stated there was a little blood on the washcloth.

R1's Nurse's Progress Notes dated 11/5/20 at 9:15 PM documents R1 had a reddened area on

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S9999	Continued From page 6 the top left palate of the mouth 0.4 cm (centimeters) triangular shape. On 11/16/20 at 3:17 PM, R1 was in R1's bed in R1's room. R1's mouth was open and R1 was staring at the ceiling. On 11/17/20 at 10:34 AM, R1 was in R1's room in R1's reclining wheelchair. R1 had braces on both hands. R1's mouth was wide open and R1 was staring at the ceiling. On 11/17/20 at 1:15 PM, V1 confirmed V4 did not report the abuse allegation immediately. V1 confirmed V4 took care of a couple of residents before V4 found the nurse and reported it. V1 confirmed that allowed V6 to still have access to the residents during that time. (B)	S9999		