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
	IL6008866	A. BUILDING: ________ B. WING ________	C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)6) 300.3240a) 300.3240b) 300.3240e) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008866	A. BUILDING: ____ B. WING ____	C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

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 facility administrator. (Section 3-610 of the Act)
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 observation, interview and record review the facility failed to ensure R1 was not physically or verbally abused. This has the potential to affect one of six residents (R1) reviewed for abuse in the sample of six. This failure resulted in R1 having bruising on R1's upper left cheek under left eye. .Further more, the facility staff failed to follow their policy to reprt witnessed resident abuse by a staff member immediately to the facility administrator. This failure resulted in R1 having bruising on R1's upper left cheek under left eye.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008866	A. BUILDING: ______ B. WING ______	C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 Findings Include: On 02/24/15 at 1:10P.M. E4 (Certified Nurse's Aide/CNA) stated that on 02/21/15, "during first medication pass about 4:30 P.M.," that E3 (Registered Nurse/RN) grabbed and held R1's face and "forced medicine into R1's mouth." E4 stated that E3 told R1 to shut up "multiple" times." On 02/23/15 at 4:30 P.M., Z1 (R1's family member) stated that Z1 came to facility "about 4:45P.M., and "staff" informed Z1 that E3 (RN) had grabbed R1's face and "forced" R1 to take medicine. Z1 stated during Z1's visit on 02/21/15 Z1 noted "redness" to both cheeks. Z1 also stated "approximately two hours after 'E3' gave R1 medicine on 2/21/2015, 'R1' started coughing and spit out a whole pill." Z1 stated Z1 then asked E3 (RN) why R1 was given whole medicine when it is supposed to be crushed and E3 told Z1 to "mind your own business" and "I don't have time to check and see who all gets crushed medicine." On 2/24/15 at 9:10 A.M., R1 had a long purple bruise approximately 4 cm (centimeters) under left eye. On 02/24/15 at 9:55 A.M. E2 (Director of Nurses/DON), E1(Admistrator/ADM) and E6 (Social Service Director) all confirmed the presence of dark purple bruise approximately 3 centimeters long on R1's upper left cheek under left eye. On 02/24/15 at 11:00 A.M. E3 (RN) confirmed that E3 did put E3's hand on R1's face while giving R1 the medication. On 02/25/14 at 10:30 A.M. E9 (RN) stated that	S9999		

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
	IL6008866	A. BUILDING: ______ B. WING ______	C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

"just before 5:00 P.M." E4 (CNA) reported that E4 witnessed E3 (RN) grab R1's face the previous evening (02/21/15). E9 stated that E9 called E2 (Director of Nursing/DON) "around" 5:00P.M., on 02/22/15. E9 stated that E2 told E9 "we have 24 hours to report it, will take care of it on Monday."

On 02/25/15 at 11:00 A.M. E2 (DON) confirmed E1 was called and texted "multiple times" on 02/22/15 in regards to E3 (RN) "having a meltdown....crying and swearing at nurse's desk and won't pass pills, won't do anything." E2 (DON) stated E2 was notified by E9 (RN) that Z1 (R1's family member) was at the facility and very upset. E2 stated that Z1could be provided E2's cellphone number if Z1 wanted to speak with E2. E2 stated that E9 called E2 in regards to E3's behavior "this nurse is crazy." E3 stated that E3 told E9 "to continue to do E9's work and 'E2' would take care of it on Monday."

On 02/24/15 at 9:25 A.M. E1 (Administrator/ADM) stated that E3 (RN) called and left a voicemail for E1 on 02/21/15. E1 stated that E3 was "very upset" during the voicemail and said "'R1s' off 'R1's rocker." E1 indicates that E1 called E3 back approximately 15 minutes later and E3 was "calm/fine."

E3's time card indicates E3 worked the entire shift on 02/21/15 from 2:03 P.M. until 10:30 P.M. and worked again on 02/22/15 from 2:02 P.M. until 11:13 P.M.

On 02/24/15 at 11:00 A.M. E3 stated that E3 was "not suspended."
E3 remained available to work until termination on 02/25/15.

On 02/25/15 at approximately 1:30 P.M. E3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 arrived at the facility in scrubs for E3's regularly scheduled shift. E1 immediately terminated E3 at that time. On 02/24/15 at 9:28 A.M. E1 stated that this abuse investigation began at 10:15 A.M. on 02/23/15. E1 stated that E1 will notify the local law enforcement if abuse is fully founded . The facility's February 2015 staffing sheet reports that E4 worked primarily on fourth floor with potential to affect residents R1-R44. The Abuse Prevention Program dated January 2009 states " All employees of this facility must immediately report any incident or suspected incidents of resident neglect,abuse or misappropriation of resident property to their supervisor or Administrator." The Abuse Prevention Program dated January 2009 states "the chain of command as established by this policy shall be followed by all personnel when filing ......complaints, and/or in emergency situation." This chain of command indicates that the administrator is the first person to be contacted. (A)	S9999		

St. Anthony Nursing and Rehabilitation Center
767 30th Street
Rock Island, Illinois 61021

Plan of Correction

The filing of this plan of correction does not constitute an admission that the alleged deficiencies did in fact occur. This plan of correction is filed as evidence of the facilities desire to comply with requirements and to continue to provide quality care.

This facility does not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

On 2/21/2015 at about 4:30 pm R1 was given an oral medication by E3. E3 gently held R1s face and encouraged her to swallow the medication. It is important to note that R1 per MDS has severe dementia.
R1 was admitted to this facility with bruises to her left eye both above and under eye and to left cheek these were documented on admission (1/19/2015).

To ensure compliance the facility has completed the following measures:

1. All staff were in-serviced on Abuse Policy and Procedure on 2/24/2015.
2. E3 employment was terminated on 2/24/2015
3. All new hires receive information on the Abuse Policy and Procedure and the policy and procedure is reviewed in orientation.
4. Random audits re the Abuse policy and procedure
5. Findings will be reported to the QA committee for review.

Completion Date: March 1, 2015 accepted

Attachment B
Imposed Plan of Correction

St. Anthony Nursing and Rehabilitation Center
767 30th Street
Rock Island, Illinois 61021

Plan of Correction

The filing of this plan of correction does not constitute an admission that the alleged deficiencies did in fact occur. This plan of correction is filed as evidence of the facilities desire to comply with requirements and to continue to provide quality care.

This facility does not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with State law through established procedures (including to the State survey and certification agency).
All alleged violations are thoroughly investigated, and prevent further abuse while the investigation is in process.
The results of all investigations are reported to officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken.

On 2/21/2015 at about 4:30 pm R1 was given an oral medication by E3. E3 gently held R1s face and encouraged her to swallow the medication. It is important to note that R1 per MDS has severe dementia.
R1 was admitted to this facility with bruises to her left eye both above and under eye and to left cheek these were documented on admission (1/19/2015).

To ensure compliance the facility has completed the following measures:

1. All staff were in-serviced on Abuse Policy and Procedure on 2/24/2015.
2. E3 employment was terminated on 2/24/2015
3. All new hires receive information on the Abuse Policy and Procedure and the policy and procedure is reviewed in orientation.
4. Random audits re the Abuse policy and procedure are ongoing
5. Findings will be reported to the QA committee for review.

Completion Date (March 1, 2015) accepted

Attachment B
Imposed Plan of Correction

St. Anthony Nursing and Rehabilitation Center
767 30th Street
Rock Island, Illinois 61021

Plan of Correction

The filing of this plan of correction does not constitute an admission that the alleged deficiencies did in fact occur. This plan of correction is filed as evidence of the facilities desire to comply with requirements and to continue to provide quality care.

This facility does not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with State law through established procedures (including to the State survey and certification agency).
All alleged violations are thoroughly investigated, and prevent further abuse while the investigation is in process.
The results of all investigations are reported to officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken.

On 2/21/2015 at about 4:30 pm R1 was given an oral medication by E3. E3 gently held R1s face and encouraged her to swallow the medication. It is important to note that R1 per MDS has severe dementia.
R1 was admitted to this facility with bruises to her left eye both above and under eye and to left cheek these were documented on admission (1/19/2015).

To ensure compliance the facility has completed the following measures:

1. All staff were in-serviced on Abuse Policy and Procedure on 2/24/2015.
2. E3 employment was terminated on 2/24/2015
3. All new hires receive information on the Abuse Policy and Procedure and the policy and procedure is reviewed in orientation.
4. Random audits re the Abuse policy and procedure are ongoing
5. Findings will be reported to the QA committee for review.

Completion Date: March 1, 2015 accepted

Attachment B
Imposed Plan of Correction