STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY REHAB AND CARE CENTER	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

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S 000	Initial Comments Investigation of Facility Reported Incident of April 13, 2023/IL159298	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent abuse by a staff member for 1 of 3 (R5) residents reviewed for abuse. A reasonable person would feel angry, intimidated, and fearful of staff from being hit and cursed at by	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 a staff member. The findings include: R5's Care Plan, dated 03/10/2023, documents "Problem: Cognitive skills for daily decision making moderately impaired - decisions poor; cues/supervision required d/t (due to) Dementia." It continues "Approach: Engage in activities that do not require frequent decisions; observe for signs of frustration. Provide assistance as needed." It also documents "Problem: Short-Term memory impaired - unable to recall after 5 minutes d/t Dementia, New Environment." It continues "Approach: Re-orient to time, location, events, and activities as needed. Approach: Provide direct guidance when resident is unable to follow through with instructions. Approach: Maintain consistent routine; introduce change slowly to reduce confusion. R5's Progress Notes, dated 4/13/2023 at 7:20 AM, documents "CNA (Certified Nursing Assistant) came and made me aware that resident had slid off the sliding board while trying to transfer. The writer came into the room to see resident lying on the floor. Resident said, nothing hurts at this time and has no bumps or bruising at this time. VS (Vital Signs), WNL (within normal limits). Resident is currently in dining room waiting on breakfast. NP (Nurse Practitioner) notified, family notified, and DON (Director of Nursing)." R5's Progress Notes, dated 4/13/2023 at 7:31 AM, documents "Administrator and DON made aware of Incident."	S9999		

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S9999	Continued From page 2 The facility's Final Report of Alleged Physical and Verbal Abuse, not dated, documents on 4/13/2023 V7 (Licensed Practical Nurse/LPN) and V17 (CNA) were called to the room of resident R5, age 79, by V18 (CNA) to assess and assist in getting R5 off the floor, due to a fall while doing a sliding board transfer with V18. All staff members assisted the resident bask into his wheelchair. Almost immediately, V18 pushed and slapped, R5 and called him a "Mother Fxxxxx" as witnessed by the 2 other staff in the room. V18 was removed from the facility immediately. Resident was assessed for injury, and none noted. Resident did not voice any complaints of pain. (Local Police) was called. Physician, Administrator, DON, and family contacted. V19 (Officer from Local Police Department) arrived at facility to investigate. Staff who witnessed were interviewed and resident was also interviewed. Resident told (V19) that he remembered the fall but does not remember being struck by an employee. V19's report is (XXXX-XXXXX). Report was still in progress as of 4/17/23 at 2p.m. Several other residents who were assigned to V18 were interviewed by the V2 (DON). No resident mentioned being hurt by V18, but a few said he was 'rough' when pulling them up in bed with draw sheet. No one interviewed has been hit or cursed at by V18. Nurse Practitioner/NP assessed and interviewed resident on 4/14/23. No injuries noted. Resident unable to recall event for NP. V18 was interviewed by V2 on 4/13/23 by phone. V18 was asked what happened with R5. V18 talked about the fall and stated without being asked "I didn't say anything disrespectful" but, did not say anything about the physical altercation. V18 was terminated at that time. Facility does substantiate the physical and verbal abuse.	S9999		

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S9999	Continued From page 3	S9999		

"The facility's Patient and staff interviews as it relates to Abuse allegations: 4/13/23" documents the following:
1. V7 (LPN) stated that she was called into patient's room, (R5), due to a fall. While trying to get him off the floor, with assistance of V17 and V18, V18 slapped the patient on the head twice and called him a "Big Mother Fxxxxx". She also stated that she smelt alcohol on his breath. After that she asked, (V18) to leave the building, notified the Administrator, called the Police, and notified DON.
2. V17 stated, around 6am her co-worker, (V18) asked for assistance with getting (R5) off the floor. She stated, when she entered the room, she saw the patient lying on his back on the floor. She then told (V18) he should get the nurse to make sure he was okay before they moved him. After the nurse assessed him, they (V18, V17, and V7) assisted him into the w/c (wheelchair), using the (full body), lift pad. Once (R5) was in the w/c, he (R5), leaned forward and asked if they needed to remove the (full body lift), pad and V7 responded "it was fine". She then stated, that (V18) pushed him back in the chair and told him to behave, then called him a "Big Fxxxxx".

On 5/1/2023 at 2:30 PM V1 stated that she did do an investigation on the incident that occurred with (R5) and a staff member. V1 stated that she was notified that (V18) physically and verbally abused (R5). V1 stated that she was proud of her staff for being advocates for the resident. V1 stated that the nurse was able to get the employee out of the facility and assessed the resident. V1 stated that she was notified that R5 did not have any injuries. V1 stated that the Police were called, and the incident was reported. V1 stated that an officer came out to the facility and interviewed the resident and the staff members.

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S9999	Continued From page 4 V1 stated that she has followed up with the police and as of current the report hasn't been completed. V1 stated, that she has also been in contact with the family, and they are upset and wanting to file a complaint as well. V1 stated that V2 performed the interviews with the staff and residents and did not find any other residents that had been abused by V18. V1 stated that some of the residents felt he was rough but not abusive. V1 stated that they were able to substantiate the abuse because they had witnesses that were vocal about what happened. On 5/2/2023 at 9:39 AM V7 (LPN) stated that she was the nurse the night of the incident. V7 stated that V18 told her that R5 had fallen and V7 needed help getting R5 off the floor. V7 stated that she (V7) and V17 went to room to help V18. V7 stated that once entering the room she observed R5 on the floor and assessed him. V7 stated that initially they attempted to transfer R5 manually but R5 would not move his legs. V7 stated that at that time V18 stated to R5 "all you had to do was move your legs." V7 stated that they then transferred R5 using the full body lift. V7 stated that once in the wheelchair V18 called R5 a "fat Mxxxxx Fxxxxx" and hit R5 in the head twice. V7 stated that V18 then said all you had to do was move your legs. You are ruining my morning you big Mother Fxxxxx." V7 stated that R5 did not say anything but you could see that he wanted to but V18 was standing over him and stated "What. You are ruining Morning you big Mxxxxx Fxxxxx." V7 stated that V18 was posturing over R5 trying to intimidate R5. V7 stated that she told V18 that he needed to leave the facility. V7 stated that V18 became aggressive with her and would not leave initially asking what he did. V7 stated that she had to tell V18 to leave multiple times before he would leave	S9999		

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the building. V7 stated that she was able to get V18 to leave.

On 5/2/2023 at 10 am R5 stated that he has had a fall, but it was the staff fault because they put him to close to the edge of the bed. R5 stated that he did not remember the employee and did not remember being cursed at or hit. R5 stated that he would not like to be hit. R5 stated that he would not have been ok with that. R5 stated that he would be angry and wanting to fight back. R5 stated that he isn't in any condition to fight back. R5 stated that not being able to fight back is scary.

On 5/2/2023 at 157 PM V13 (R5's Sister) stated that she was made aware of the incident with her brother and the staff member. V13 stated that R5 has dementia and has short-term memory problems. V13 stated that R5 would have never tolerated being hit or cursed at. V13 stated that R5 would have felt like anyone else in that situation. V13 stated he would have been angry, intimidated and scared all at the same time. V13 stated that how would you feel if this was done to you? V13 stated that they are thankful that the staff spoke up about the situation with her brother but what about the times they were not there and what about the other residents that were cared for.

On 5/3/2023 at 2:15 PM V2 stated, that she interviewed V18 by phone. V2 stated, that she asked V18 what happened with R5. V18 stated, that R5 had fallen. V2 stated that she asked is that all that happened and V18 responded I didn't say anything wrong. V2 stated, that she asked again if that was all that happened with R5 and V18 stated, that he didn't know what she was talking about. V2 stated, that informed V18 that

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S9999	Continued From page 6 his services were no longer needed. The facility's Abuse Prevention Policy, dated 8/2016, documents "The facility believes that each resident has the right to be free from abuse, neglect, corporal punishment, misappropriation of their property, involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other Residents residing at (facility), consultants, volunteers, staff of outside agencies providing services at (facility), family members, legal guardians, and individuals visiting our facility." "B"	S9999		