STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

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S 000	Initial Comments Complaint Investigation: 2349962/IL167265	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 300.1210 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	S9999		

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to prevent staff to resident abuse for 1 of 3 residents (R2) reviewed for abuse in the sample of 17. This failure resulted in V8, Certified Nurse's Assistant, CNA, being rough with R2 and verbally abusing R2. A reasonable person would not want to be treated roughly during care and verbally abused. Findings include: R2's Admission Record Form, dated 12/3/23, documented R2 was admitted to the facility on 1/31/23 with diagnoses of dementia, anxiety disorder and fracture of unspecified part of neck of right femur. R2's admission record form documented a diagnosis (with an onset dated 8/9/23) of acute embolism and thrombosis of another specified deep vein of right lower. R2's admission record form documented diagnosis (with onset dates of 8/17/23) of unspecified fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing, unspecified fracture of unspecified femur,	S9999		

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S9999	Continued From page 2 subsequent encounter for closed fracture with routine healing. R2's Minimum Data Set (MDS) dated 11/6/23, documented R2 as being severely cognitively impaired. R2's Care Plan, dated 6/8/23, documented, "Requiring a mechanical lift and assist of 2 for all transfers." On 12/4/23 at 11:30 AM, V14, R2's sister/Power of Attorney (POA) stated, "Some of these young kids do not have compassion and some of the CNAs are rough. I have video of a (Certified Nurse Assistant) named, (V8), tossing my sister around back and forth, yanking on her hands, and being rude." V14 stated she went to V7, Social Worker, and she said she had to report it to the Administrator. V14 stated she showed them both the video and they said they would speak to V8 about it. V14 stated that when she visited R2 on 11/28/23 she observed a large bruise covering R2's right hand. R2's Video and audio footage, dated 11/26/23 at 6:40 AM, was observed by surveyors. Observations made were R2 was nude and lying in bed. V8, CNA, turned R2 to her left side while placing a disposable undergarment on R2. V8 stated, "Stop, let go before you rip it, let go of my finger, man!" V8 abruptly pulled her hand away and stated, "There's no reason for you to hold on to me and squeeze my fingers like that, that hurts!" R2 stated "I'm sure it does hurt." V8 replied "Then stop!" V8 then rolled R2 onto her left side in a rough manner. V8 stated to R2, "Put your shirt on, come on put your sweater on, stop holding onto me!" R2 continues to be resistant with dressing and V8 was observed tightly holding	S9999		

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S9999	Continued From page 3	S9999		

R2's right hand. R2's Video and audio footage dated 11/26/23 at 6:43 AM, showed V8 pulling R2's pants up and R2's sweater down while R2 was lying in bed on her left side. V8 turned R2 onto her back in a rough manner and firmly grabbed R2's right hand. V8 stated "Stop digging your nails into my skin now, let go!" V8 walked away from R2's bed and left the bed in the high position. V8 retrieved the mechanical lift sling and placed it under R2 as R2 was lying on her left side. V8 turned R2 to her right side in a rough manner while bringing R2's left hand over on top of R2's right hand and then V8 used her left hand and arm to restrain R2's hands. V8 then shifted her body weight to increase pressure on top of R2's hands and wrists. R2 stated. "Ow!" V8 then turned R2 onto her back. V8 stated to R2, "You're terrible!" R2 stated, "What?" and V8 replied "You are terrible, why do you keep trying to hit me and pinch me?" V8 then lowered the bed and left the room.

On 12/4/23 at 12:10 PM V1, Administrator, stated "We didn't report the video concerns because we cleared it on the spot when the sister (V14) brought it to me and our Social Worker. While we didn't like her behavior, we didn't feel like it rose to the level of abuse, so we didn't report it."

On 12/4/23 at 12:30 PM, V7, Social Worker, stated, "When the family showed me the video, I was adamant that we had to report it to the Administrator." V7 stated that V14, R2's sister/POA, said she didn't want to get anyone in trouble. V7 stated "In my opinion, I think the CNA could have handled it differently, but we don't feel it was abuse. We didn't feel it was intentional. The CNA apologized the next day to (V14)."

On 12/5/23 at 4:40 AM V17, Registered Nurse

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S9999	Continued From page 4	S9999		

(RN) stated that she feels that some of the staff speak to residents in a rough tone especially if it is a resident who was being resistive to care. V17 stated that she thinks that some of the staff need more education regarding dementia care. She continued to state that she would report them to (V1, Administrator) or to (V23, ADON) who was over the CNAs.

On 12/5/23 at 1:20 PM V8, CNA, stated, "On 11/26/23, I went to get (R2) dressed and I felt myself getting worked up, so I lowered her bed and walked out." V8 stated, "I grabbed her wrist softly at times to redirect her and I did not see any bruises on her hands or wrists." V8 continued to state "The ADON (Assistant Director of Nursing) came to me later that day and said (R2's) sister showed me the video. V8 stated "(V23) knows how her sister is and (V23) didn't want me to get in to trouble." V8 stated, "(V23) told me to talk to the sister, so I did, I apologized, and her sister hugged me and said I am a good CNA." V8 stated "They did not send me home, they just put me on another hall."

R2's Progress Note, dated 11/26/23 at 3:31 PM, documented, "Bruise was noted to R (right) index finger. No s/s (signs or symptoms) of pain noted when assessing finger. ROM (range of motion) WNL (within normal limits). POA (power of attorney) notified. Will monitor.

R2's Facility's incident report form, dated 11/26/23, documented, "Resident frequently combative with staff. Resident noted to have hands folded on lap frequently. Likely bumped on table at meal or over bed table. Nurse and CNAs interviewed, and no areas of concern noted."

The facility could not provide documentation of

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S9999	Continued From page 5	S9999		

investigation, including witness statements and root cause analysis. It also could not provide documentation that the state agency was notified.

An electronic mail (email) dated 12/06/2023 at 11:23 AM, from V1, Administrator, documented, "Our morning meeting ran over and then Wednesday Medicare Mtg, but I wanted to get you at least the Abuse Policy as it relates to investigations and procedures. Our employees are also given a copy of this entire policy at hire and sign a form they received it. (V2, DON, V23, ADON and V1, Administrator) reviewed it again this morning at 8am to make sure we felt we followed the policy. While hindsight is always 20/20, we still don't believe the definition listed of verbals, physical or mental abuse in our policy was met by (V8, CNA) lack of warmth and patience with (R2). Harsh tone, yes. Abrupt care, yes. "Willful disparaging and derogatory terms to the resident, threats of harm or isolation" were not present. Harassment and threats of punishment, not present. Hitting, slapping, pinching, kicking and corporal behavior, not present. After further discussion, we all agree that (V14, R2's sister/POA) came to (V7, Social Service) saying she had a "concern", but asked us not to report (V8, CNA) because she didn't want her to lose her job or get in trouble. Our conclusion was that this was not an allegation of abuse by the sister, but dissatisfaction with level/type of care/attitude/tone. In summary, it didn't meet our policy's definition of abuse as it's laid out. Going forward, we will err on the side of caution, take your advice, and over-report. We feel we followed our policy and did a "best practice" decision of removing (V8, CNA) from the hall, speaking to her about her tone and abruptness of care, and respecting the family's wishes that she will not be fired or be made to be

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S9999	Continued From page 6 "in trouble". It was only after (R2) passed from an unrelated rapid onset medical condition that this "concern" resurfaced and was escalated beyond what the sister originally asked us to do. We still struggle with the position we were asked to be in, but next time, we will report despite family asking us to handle it internally, per again, erring on the side of caution. Thank you!" The facility Abuse Prevention Program Policy and Procedure, dated 9/26/23, documented, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and has attempted to establish a resident-sensitive and secure environment." (A)	S9999		