STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. BUILDING _____ B. WING _____	C 01/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HOME, THE	**150 NORTH 27TH STREET BELLEVILLE, IL 62226**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #0940336/IL39362 An extended survey was not conducted.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that 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 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 225	Continued From page 1 survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation the facility failed to thoroughly investigate, take measures to prevent further abuse and immediately report all alleged violations of mistreatment or abuse to the administrator and the Department for one of three residents reviewed, R3. Findings include: R3 was admitted to the facility from the hospital on 1/8/09 with diagnoses, in part, of anemia, arthritis, hypertension and angina pectoris. R3 began having diarrhea and was diagnosed with clostridium difficile (C-diff) on 1/20/09. R3 was assessed on the 1/15/09 Minimum Data Set (MDS) as independent for cognitive skills and needed extensive assistance from one person for toilet use, bed mobility and hygiene. The facility identified R3 as interviewable. In an interview with E3 (Licensed Nurse) on 1/28/09 at 3:30 PM she stated that E12 (Certified Nurse Aide) had come to her on 1/14/09 and stated that she needed to speak to R3 and her family. E3 stated E12 did not give any specifics. E3 stated she went to the room of R3 and R3 stated that a nurse had told her not to put her call light on. R3 stated it was the night shift the day before that it occurred. E3 stated that R3 did not	F 225		

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F 225	Continued From page 2 mention that the staff had cussed or threw anything at her. E3 stated that R3 could not give a description of the staff, but did say she was a "white lady". E3 stated she told R3 if she saw the person again to try and remember who it was. E3 stated she passed the information onto R3's nurse, E7. E3 stated she did tell E7 and wrote a statement regarding the incident. E7 (Licensed nurse) was interviewed regarding the incident on 1/28/09 at 3:20 PM. E7 stated that on 1/14/09, R3 told her it happened the night before. E7 stated R3 did not mention that the staff had cussed at her or threw anything at her. In E7's written statement dated 1/14/09 it noted that R3 "stated "I put my light on & CNA came in & told me not to turn it on". res upset & stated "I just needed help" unable to say who it was just stated "a white girl" & stated "it happened last night." E7 stated she got statements form staff regarding the incident. E7 stated that she wrote the statement for E12 (CNA) and he signed it. E7 stated that she did not call anyone such as the administrator, about the incident. E7 stated she put the written statements in the Assistant Director of Nursing mail box that night. In the written statement of E12, which was written by E7 and signed by E12, it stated "Res's daughter told (E12) that a nurse aide threw a towel at her mother last night & told her not to turn the light back on. Res. daughter stated "I'm displeased by her actions" (E12) then told (E3) LPN & E3 went in & talked to family." E9 (Licensed Nurse) was interviewed on 1/28/09 by phone. E9 stated that R3 told her that a CNA came into her room and pulled her covers back to see if she was wet. E9 stated the CNA said	F 225		

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F 225	Continued From page 3 something cleaning her up to the effect that R3 was a "mess". E9 stated that R3 was having loose stools due to the C-diff E9 stated that R3 stated to the CNA that she would clean herself up. E9 stated that R3 stated the CNA threw a wash cloth at her. In the interview E9 stated that they were not sure which CNA it was and that she did not know what shift it happened. In the written statement by E9, dated 1/15/09 at 2:00 AM addressed to E4 (Assistant Director of Nursing) it stated "(R3) in 303-2 called me into her room, she was very upset & crying. She claims that (E10, CNA) was the one that was mistreating her and that she didn't understand why... She said that E10 told her not to "mash her button". I re-assured her that I'd send another CNA into her room & that (E10) was not to go into her room anymore. She also said the other morning that she/(E10) had come in her room, pulled down her blanket & saw she had made a diarrhea mess on herself, then put the sheet & covers back over her and refused to clean her up. Resident said she would clean herself up if she's given her a wet washcloth...". E4 stated in an interview on 1/28/09 at 1:30 PM that E9 had given her a note regarding E10 note giving R3 a washcloth. Her written statement dated 1/19/09 stated "In regards to the incident with R3, I spoke with the night shift staff about her complaint, because E10's name was mentioned as a possible person in the conflict. I spoke with E4, the aide regarding R3. E10 told me she asked for a washcloth and she gave her one. She left the room to give the resident some privacy. Returned to the room and took the wash cloth and put it in the hamper. Do to the fact that the resident could not identify the staff member. I	F 225		

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F 225	Continued From page 4 moved E10 off the hall to see if there would be any more concerns with R3. There were no concerns that night or when R3 was allowed to work on the hall again that night. There was no concerns that night regarding R3 with patient care. Because R3 could not identify anyone definitely as the person and could only say it was a white can, who allegedly was rude to her, in conclusion we decided to continue to monitor the situation for anymore complaints or concerns. No other complaints have been brought to our attention concerning her." In an interview with E4 at 4:05 PM on 1/28/09 she stated that she had not interviewed R3. E10 (CNA) was interviewed by phone on 1/28/09 at 2:10 PM. E10 stated that she had given E9 a written statement regarding R3. E10 stated that she was taken off R3's care because R3 "said someone had cussed her out & threw a wash cloth at her". E10 stated that she had not done this. E10 stated that she only talked to E4 regarding the allegation. Review of the staffing schedules for E10 noted that she worked the 11:00 PM to 7:00 AM shift. E10 finished her shift on 1/14/09 after the allegations were reported to staff. E10 worked 1/1509 thru 1/19/09, 1/21/09 thru 1/23/09, 1/26/09, and 1/27/09. In an interview with E2 (Administrator) on 1/28/09 at 1:00 PM, she stated that R3 said a CNA wouldn't give her a washcloth. E2 stated R3 couldn't say who it was. E2 stated at 4:15 PM that she had talked to R3 but there was no documentation to support this. E2 stated that the incident had not been reported to the Department because they didn't feel it was abuse.	F 225		

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F 225	Continued From page 5 R3 was interviewed on 1/28/09 at 12:30 PM. R3 was asked if she was getting her bath and she stated yes. R3 was asked if staff was nice to her and she looked down and smiled. When she was asked if any staff was mean to her she just shrugged her shoulders. When R3 was asked if any staff had cussed at her she smiled but did not say anything. On 1/28/09 at 4:00 PM R3 was again asked if staff were mean to her she was reluctant to say anything. R3 was asked if any staff had thrown a washrag at her and she stated "Yes". R3 was asked if staff had cussed at her and she laughed. R3 then said that this staff was mean to her 3-4 times but must have heard something because she was nice after that. R3 stated "I know who it was" and that she had shown the nurse who had thrown the washrag at her. R3 stated she hasn't seen that staff for a week. According to the policy and procedure "Abuse Prevention Program" states that the administrator or designee shall be notified immediately of all reports of potential mistreatment. It further states that employees who have been accused of mistreatment will be removed form resident contact immediately until the results of the investigation have been reviewed. It states that "Employees accused of possible mistreatment shall not complete the shift as direct care provider to residents". The policy and procedure states "If, during the course of an incident investigation, the administrator or designee has determined that there is reasonable cause to suspect mistreatment has occurred, the residents representative and the (Department) shall be informed immediately". The policy states	F 225		

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F 225	Continued From page 6 that within 24 hours a written report shall be sent to the department and a final investigation report with five working days.	F 225		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement policies and procedures that prohibit alleged mistreatment and abuse of one of three records reviewed, R3. Findings include: On 1/14/09, R3's family stated to E12 that a facility staff had thrown a towel at R3. A written statement from E3 dated 1/14/09 also stated that staff had refused to help her. E3 stated in an interview on 1/28/09 that she had reported the incident to E7, licensed nurse. E7 stated she did talk to R3 who stated R3 had told her not to turn the call lite on. E7 stated that she did write the statement for E12 that said a staff had thrown a towel at R3. E7 stated she got statements form the staff but did not call the administrator. E9, Licensed Nurse, noted in her written statement that R3 called her to her room, crying and upset, and stated E10 was mistreating her. The written statement also noted that E10 refused to clean R3 up after an incontinent episode. E9 stated in a written interview on 1/28/09 that R3 had stated E10 had thrown a washrag at her. E10 stated she left the statement for the Assistant Director of	F 226		

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F 226	Continued From page 7 Nursing the next morning. E10 stated she had taken E10 off of R3's care. E10 continued to work. Review of the schedule noted that E10 continued to work after R3 had stated to E9 who the staff was that had mistreated her. E10 was taken off R3's care on the night of 1/14/09. E7 stated in an interview on 1/28/09 that she was taken off her care the night of the 14th as R3 had stated a staff had cussed at her and threw a washrag at her. Interview with E2 on 1/28/09 noted that the Department was not contacted regarding the allegations. E2 stated that they did not contact the Department because they did not feel any abuse had occurred. In an interview with R3 on 1/28/09 she confirmed that a staff had thrown a washrag at her. R3 also stated that she knew who the staff was that had done it and had reported it to the nurse. R3 was assessed on the MDS dated 1/15/09 as independent for cognition. According to the policy and procedure "Abuse Prevention Program" states that the administrator or designee shall be notified immediately of all reports of potential mistreatment. It further states that employees who have been accused of mistreatment will be removed form resident contact immediately until the results of the investigation have been reviewed. It states that "Employees accused of possible mistreatment shall not complete the shift as direct care provider to residents". The policy and procedure states "If, during the course of an incident investigation, the administrator or designee has determined that there is reasonable	F 226		

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F 226	Continued From page 8 cause to suspect mistreatment has occurred, the residents representative and the (Department) shall be informed immediately". The policy states that within 24 hours a written report shall be sent to the department and a final investigation report within five working days.	F 226		