STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	1102 WEST RANDOLPH ROANOKE, IL 61561

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S 000	Initial Comments Complaint Investigations Licensure Violations 1927786/IL116845 1927819/IL116886 1927827/IL116903 1927858/IL116930	S 000		
S9999	Final Observations Licensure Violations 300.610a 300.3240a) 300.3240b) 300.3240c) 300.3240d) 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.	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
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S9999	Continued From page 1 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (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. These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect two residents (R1, R2) from physical, verbal, and psychological abuse for two of three abuse allegations	S9999		

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S9999	Continued From page 2	S9999		

reviewed. The facility failed to identify potential abuse, investigate an allegation of abuse, and failed to remove the alleged perpetrators from the facility immediately for three residents (R1, R2, R3) of three abuse allegations reviewed. This resulted in serious psychosocial harm and extensive bruising and pain of R1's bilateral wrists and hands. This failure has the potential to affect all 42 residents residing in the facility.

Findings include:

The facility's Abuse Prevention policy, dated 2/21/18, documents, "Abuse: Willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse: Including but not limited to hitting, kicking, pinching, choking, shoving, pushing, biting, slapping, punching, striking with an object, burning, cutting. Possible indicators: cuts, laceration, puncture wounds, bruises, welts, discoloration. Verbal/psychological abuse: Including but not limited to words, signs, gestures to intimidate and demean, cursing, harassing, ridiculing, and threatening. Possible indicators: helplessness, hesitation to talk openly, implausible stories, confusion, disorientation, anger, fear, withdrawal, depression, denial, and agitation." The policy also documents, "Behavior Management & Catastrophic Reactions: If a resident becomes agitated and will not be distracted, make sure they are safe and leave the area."

1. R1's BIMS (Brief Interview of Mental Status), dated 8/19/19, documents a score of 11 (moderately impaired cognition).

R1's Care plan, dated 8/27/19, documents, "R1 is usually in a good mood, but may make negative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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APOSTOLIC CHRISTIAN HOME	1102 WEST RANDOLPH ROANOKE, IL 61561

(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		

comments." The care plan also documents, "R1 may display behaviors such as anger/verbal abuse toward staff. R1 may display that during time of ADLs (Activities of Daily Living)." An approach/intervention that was documented regarding these behaviors was: Explain to R1 what you will be doing prior to working with her. If R1 refuses, explain consequences of not participating in cares needed. If R1 become angry and begins raising her voice or starts to verbally abuse staff, remind R1 that you respect her and that she needs to respect you also. Ensure that R1 is safe. Leave R1 and allow her to calm down and approach later.

On 10/22/19 at 2:55 p.m., V3 (Certified Nursing Assistant-CNA) stated, "I got to the facility (10/17/19) at 4:00 p.m. V5 and V6 (Both CNAs) told me that R1 was combative during cares and they showed me the scratches on their arms. I told them to just let me care for her the rest of the night so it would be a different person. I went in to check on R1. She had dried blood on her lips. Then, I found that she had blood in her mouth. I asked her what happened. She was upset, crying, and paranoid. R1 stated, 'Two girls held me down and one pulled my dentures out.' I cleaned her mouth out and tried to comfort her as much as possible. She had so much blood in her mouth I couldn't tell if R1 had any sores or not in her mouth. After, I got her mouth cleaned out, R1 stated, 'I wish I could make them drink their blood like they did to me.'" V3 also stated, "R1 used to be crabby then about a month ago R1 got sick, and R1 was more mellow and passive more friendly. Thursday (10/17/19) when I came in R1 was paranoid and terrified. R1 knows who I (V3) am so she was trying to protect me (V3). R1 kept saying you (V3) can't be in here they are going to find you (V3) and they are listening. R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	S9999		

scared to death crying fearing they were going to hurt her again. When I (V3) did rounds (10/17/19) R1 was acting nervous each time I (V3) was in there acting scared. R1's behavior were worse on Saturday (10/19/19). R1 wasn't eating or taking her medications. R1 was scared to let anyone to care for her. R1 didn't want anyone to do anything with her like changing or washing her up. Saturday (10/19/19) and Sunday (10/20/19) night R1 would just start to tear up for no reason. We even were trying to distract her from thinking about the incident. Even up until tonight (10/22/19) R1 was so scared that they (perpetrators) were still around and worried when I came into her room. That they were listening to us and were going to hurt us. She has not ate anything since Friday (10/18/19) morning. She's not eatten anything. She was eating really good prior to this. She is just a completely different person. Her and I would joke around back and forth. There is no joking, now she just seems to be upset all the time. As of Sunday (10/20/19) she was still telling myself and other staff the same story of what happened. All night last night, R1 was saying her hands hurt. When I go in I'll rub the top of her hand to let her know I'm in the room with her. She grimaced when I lightly touched it and said her hand was really sore. Over the weekend (10/19-10/20/19) I didn't see her sleeping at all R1 was just constantly watching out the door."

On 10/22/19 at 1:15 p.m., V5 (CNA) confirmed that she removed R1's dentures on the evening of 10/17/19, and stated, "R1 was refusing to allow us to take her dentures out. The corners of her mouth were bleeding. We needed to get the dentures out. Then afterwards R1 got really upset with me and started becoming combative, hitting, and scratching us (V5 and V6 CNA). Even though

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	1102 WEST RANDOLPH ROANOKE, IL 61561

(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 5	S9999		

R1 was combative we (V5 and V6) continued with her cares."

On 10/22/19 at 1:30 p.m., V6 stated, "In report we were told that R1's dentures needed to come out. Obviously, we aren't going to leave the dentures in if there were sores even if R1 was refusing. R1 was trying to hit, punch, bite, and kick V5 while she was trying to get R1's dentures out. Then, the behaviors continued throughout the rest of her cares too. R1 kicked the crap out of both of us. We looked like we had been in a cat fight. Normally, we do approach at a different time. R1 told us no and said, 'I'm leaving my dentures in.' We told her they needed to come out because of sores. We didn't know that R1's gums were bleeding. I didn't see any blood before or after we took the dentures out."

On 10/22/19 at 3:00 p.m., V4 (Licensed Practical Nurse) stated, " I instructed V5 and V6 to take R1's dentures out. R1 was refusing to allow them (V5 and V6) to take her teeth out. R1 always doesn't want her dentures out. We can't even hardly be quick enough getting them out to clean them before she wants them back because she hates going without her dentures. V5 and V6 were covered in the scratches and marks because of getting R1's dentures out.

On 10/22/19 at 12:30 p.m., V2 (Director of Nursing) stated that R1 was refusing to have her dentures removed, but she needed her teeth out regardless.

R1's Nurse's notes, dated 10/18/19 at 12:32 p.m., documents, "R1 refused breakfast, lunch and 12:00 p.m. medications stating she was upset and did not want to eat."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 6	S9999		

R1's Nurse's notes, dated 10/18/19 at 8:04 p.m., documents, "(R1) upset with bedtime cares, swinging arms, hitting at CNAs, kicking and yelling at CNAs, scratching CNAs causing deep marks to CNAs' skin."

R1's Nurse's notes, dated 10/19/19 5:37 a.m., document, "Right hand has irregularly shaped red/purple bruise across top of hand, 10 cm (centimeters) x 12 cm. Left middle finger has purple bruise 4.5 cm in length extending from first knuckle to second knuckle. Left forearm has 4.5 cm x 3 cm red/purple bruise, the side of left index finger space between index finger and thumb has 3.5 cm x 5 cm dark purple bruise."

On 10/23/19 at 9:40 a.m., V7 (CNA) stated, "I was there on Friday (10/18/19) 3rd shift. R1 was physically scared of us as caregivers to take care of her. R1 was physically shaking and crying when we tried to take care for her. R1 had the look of being lost. She can be troublesome, but the other CNAs and I normally don't have any issues with her. R1 clawed at my arm when we turned her, and she has never done this to me before. I reported this to the nurse, and said she's never done this to me. I also told them R1 is not acting right. She is traumatized by something. She's not even eating. R1 hasn't eaten since Thursday (10/17/19). If someone is in the room that she doesn't trust she say she doesn't want to talk to them. R1 had had bruises on her bilateral wrists, her right upper arm/shoulder area, and left forearm. To touch her left hand/wrist she would tell you it hurt. The way she is acting now is not a behavior she seems traumatized. She's continuing to act like she is fearful. R1 is crying when we provide cares. I just want R1 and the other residents to be safe. It breaks my heart that this smiling happy woman who could be a little

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 7	S9999		

troublesome at times is now this scared fearful woman who is scared of all of us."

R1's Nurse's notes, dated 10/19/19 at 3:11 p.m., document, "R1 did pinch one CNA and called them names. R1 also stated she wanted to kick them in the face and make them drink blood like she is. RN asked if she would like to get up for supper, even if she would like to stay in her room, resident declined stating she does not want to eat."

R1's Nurse's notes, dated 10/19/19 at 6:27 p.m., document, "Several bruises to left and right arm. Right wrist has significant bruising and swelling, she also has bruising to back of right upper arm. Resident is very quiet during bath. R1 cried off and on during her bed bath. R1 refuses any medications or food."

R1's Nurse's notes, dated 10/20/19 at 1:00 a.m., document, "Offered food and nourishment which R1 refuses. R1's eyes darken with moisture when nurse expresses desire to help her."

R1's Nurse's notes, dated 10/20/19 at 8:30 a.m., document, "R1 refused room tray, giving very short angry responses to questions. At one point CNAs offered her a drink and she responded with hell no."

R1's Behavior Monitoring events, dated 10/20/19 at 1:08 p.m., document, "Pinching, cussing, grabbing, threatening to punch staff, hitting, and pushing."

R1's Nurse's notes, dated 10/20/19 at 5:47 p.m., document, "R1 refused to get up out of bed. Refused supper tray when offered and refused any of her suppertime medication."

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	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 8	S9999		

On 10/23/19 at 2:00 p.m., V9 (Registered Nurse) stated, "Saturday (10/19/19) I worked 2:00 p.m. to 10:00 p.m. I went to check on R1 and I found the bruising. R1's right wrist was swollen and covered in bruising along with bruising on the left wrist. While doing cares R1 told the CNA I'm going to kick you in the mouth and make you drink your blood like I had to.' R1 cried frequently and was very terrified. R1 wasn't the normal R1 we know. She normally jokes and talks with staff. R1 was listening for every sound. Anytime she heard something in the hall she would say, 'Who is that? Don't let them in here.' When she wasn't acting scared she would just stare at the wall. R1 did complain of her wrist hurting. These behaviors are different now, in the past some CNAs had issues with her complaining of getting up, but she would never refuse medications or food. She was never scared and paranoid. R1's never expressed these behaviors before."

On 10/28/19 at 2:15 p.m., V22 (CNA) stated, "Sunday (10/20/19) I worked 4:00 p.m. to 10:30 p.m. When we (V25 CNA and V22) went in R1 kept saying, 'Shut the door. Shut the door. They are going to get you too.' R1 knew who we were. We tried to get R1 to eat or drink. She refused to eat or drink anything. She had not been out of bed at that point since Thursday night. V25 and I provided care and she was horrible. Her eyes were bugging out, but she wouldn't look at us at all. R1 acted traumatized. She didn't want us to even touch her. This is not behaviors she is scared to death. She was unhappy at times but never like this before. Monday (10/21/19) and Tuesday (10/22/19) night I checked in on her and she still acted scared. Please believe me these are not behaviors this is not R1. V22 began crying and stated, "Nothing like this should have ever

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 9	S9999		

happened," tears in V22's eyes and lips trembling. "If a resident refuses you walk out and let the nurse know. R1 is in her right mind to know that she can refuse to take her teeth out. There's no reason why she can't leave them in. They use lots of glue on her upper dentures, and you have to pry them out. I can't imagine them trying to get her dentures out while she is fighting them.

On 10/22/19 at 10:55 p.m., V8 (Registered Nurse) stated, "I came into the facility (10/20/19) to sit with R1. When I sat with her she was in a different state of mind. R1 always knows who I am and has talked to me about my son. She normally smiled when I went into her room. She can be an unhappy person but she always smiled at me. So different wise she wouldn't smile she just stared at me and was reluctant to talk at all. I didn't actually ask her what happened. R1 seemed to be very afraid of noises in the hallway always looking at the door. R1 seemed scared and had very few words. R1 was telling me be careful they would follow me. I saw the bruises on her hands. Something had happened to R1 for her to act this way, and it wasn't good."

R1's Nurse's notes, dated 10/22/19 at 12:34 a.m., document, "R1 awake at this time. lying supine, eyes wide open, when nurse entered dark room, 'Who are you?' she said. As nurse said her name, R1 said, 'Oh come over here.' R1 asked nurse to, 'Stay, don't leave right away.' R1 spoke in a clear voice and her eyes were very alert and looking to the door at every sound, raising her head up and asking who it was. When light touch applied to her left lower arm and hand, she winced and pulled her hand away from nurse saying, 'Ouch, don't squeeze that."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 10	S9999		

R1's Behavior Monitoring events, dated 10/23/19 at 1:47 p.m., documents, "(R1) refusing cares, meals, drinks. When asked questions gives very short, terse answers."

R1's Medication Administration History, dated 10/1-10/23/19, document that up until 10/19/19 R1 was receiving her medications on a regular basis. The history also documents that R1 was refusing to take her medications on 10/19-10/23/19.

On 10/23/19 at 2:30 p.m., V30 (Dietary Manager) provided R1's Food Intake Record, dated 10/19. R1's Food Intake Record documented that R1 has had no intake of meals since supper of 10/17/19. V30 stated, "R1 has not eaten anything since supper on 10/17/19 according to this intake record."

On 10/22/19 at 9:45 a.m., R1 had a large dark purple bruise to her right wrist extending into thumb area. The entire top of R1's left hand had light purple bruising that extended above her wrist, and scattered dark purple to light purple bruising to her bilateral. arms small skin tear to left arm. R1 stated that she's not having a good day, but it's none of this surveyors business why it's a bad day. She also turned to the wall, and stated she didn't want to talk to this surveyor.

On 10/22/19 at 11:35 a.m., V11 (Registered Nurse) assessed R1's bilateral hands. R1 had light purple bruising noted throughout the entire top of left hand. R1 states, "It hurts." R1 grimaced when V11 asked R1 to perform range of motion in R1's left hand. R1 was unable to make a fist or grasp states pain in her left hand is a 9 on a scale of 0-10. R1's right hand and wrist had dark purple bruising on approximately half of the top of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	1102 WEST RANDOLPH ROANOKE, IL 61561

(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 11	S9999		

hand including R1's thumb. V11 asked R1 how the bruising happened and R1 stated, "It was those women who held me down. One was up top and two were down low. I'm not giving names because I don't want this happening to me again. It all started with them taking out my teeth." R1 acted angry and only stared at the wall stating, "I told them No and they took my dentures out anyways."

On 10/23/19 at 9:25 a.m., V27 (Licensed Practical Nurse) stated, "R1 will normally get up and eat. Now, R1 is refusing to get out of bed and eat. R1 didn't get out of bed or eat anything the entire weekend (10/19-10/20/19). It wasn't until yesterday (10/22/19) morning that they could get R1 to get out of bed, but R1 still isn't eating."

On 10/23/19 at 10:35 a.m., R1 was asked by this surveyor if R1 was experiencing pain. R1 stated she did not want to talk to this surveyor. This surveyor reassured R1 that it was safe to talk to me. With tears in her eyes, R1 stated to me, "You weren't here when I needed you," and R1 asked the surveyor to leave the room.

On 10/23/19 at 1:00 p.m., V26 (R1's Family) sitting at R1's bedside. stated, "Something has happened this isn't normal for R1. I've been here the last three days while they have been giving cares, and she acts absolutely petrified. During cares, R1 is literally shaking and crying scared of what could happen. R1 is able to hold my hand with her left hand but she is unable to completely close her hand around my hand or make a fist. R1 has obviously has sustained some kind of injury."

During this investigation, interviews with V3, V7, V10, V11, V12, and V20 confirmed that R1 made

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000384	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	1102 WEST RANDOLPH ROANOKE, IL 61561

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S9999	Continued From page 12	S9999		

the same allegation to each of these staff members that R1 was held down and her dentures were ripped out of her mouth. V1 also confirmed that V2 was aware of R1 making this statement also.

On 10/23/19 at 11:10 p.m., V14 (Social Services Director) stated, "At times, during cares R1 would occasionally get agitated and refuse cares. She would yell and call people names. I've just been made aware this week of the increase in R1's behaviors lately. R1 hasn't been coming out for meals, and R1 was typically a person who would come out for all meals. This week she has been refusing to eat, refusing medications, refusing cares, and refusing to allow housekeepers to clean her room. The behaviors of being fearful of the staff and paranoid that someone is going to hurt her are new behaviors for her. Also, the refusing to get out of bed and to eat is also new. R1 didn't have these behaviors before."

On 10/30/19 at 1:50 p.m., V2 provided the Nurse and CNA schedules, dated 10/2019. V2 confirmed that these schedules were accurate and up to date. The nurse scheduled documented that V4 worked the following shifts: 10/17/19, 10/18/19, 10/21/19, 10/22/19, 10/23/19, 10/24/19, 10/26/19, 10/27/19, 10/29/19, and 10/30/19 during 2nd shift with the hours of 2:00 p.m. to 10:30 p.m. specifically assigned to R1's hall for each of these shifts. The CNAs scheduled documented that V5 worked the following shifts: 10/17/19, 10/20/19, 10/22/19, 10/24/19, 10/29/19, and 10/30/19 on 2nd shift 2:00 p.m. to 10:30 p.m., and on 10/19/19 from 2:00 p.m. to 6:00 p.m. Of these seven shifts, V5 was specifically assigned to caring for R1 four shifts. The schedule also documents that V6 worked: 10/17/19, 10/21/19, 10/22/19, 10/24/19, 10/25/19,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13	S9999		

10/28/19, and 10/29/19 on 2nd shift from 2:00 p.m. to 10:30 p.m., 10/18/19 from 4:00 p.m. to 10:00 p.m., 10/19/19 2:00 p.m. to 6:00 p.m., and 10/23/19 from 5:00 p.m. to 9:00 p.m. Of these ten shifts, V6 was specifically assigned to care for R1 six shifts.

On 10/30/19 at 1:50 p.m., V2 stated, "V4, V5, and V6 continue to care for R1. I never determined that any of the allegations were potential abuse. Therefore, there was no need to remove V4, V5, or V6 from caring for R1." V2 also confirmed that all three staff have been scheduled to care for R1 since the incident 10/17/19, and if they are not scheduled on R1's hall they still cover those halls during other staff members' break times."

On 10/23/19 at 11:45 a.m., V24 (R1's Physician) stated, "This incident could have been considered abuse, and yes the facility should have investigated it as such."

On 10/29/19 at 11:35 a.m., V21 (Medical Director) stated, "If R1 continues to refuse to eat, refuse cares, and refuse medications this could lead to her death. The staff should have left R1 alone when she verbally refused to have her dentures out and then became combative. There is not a whole lot of harm related to leaving a resident's dentures in. By continuing cares while R1's being combative puts R1 at risk for injuring herself."

2. R2's Minimum Data Set assessment dated 9/23/19 documents diagnoses of Depression and Anxiety Disorder, and that R2 is severely cognitively impaired.

On 10/23/19 at 2:10pm, V9, Registered Nurse (RN), stated she was working on 10/6/19 when she heard V13, CNA, yelling "I'm tired of you (R2)

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S9999	Continued From page 14	S9999		

treating me like s**t, this has to stop now!" as V13 left R2's room. V9 stated she thought this was verbal abuse. V9 stated she called V2, Director of Nursing (DON) to report the verbal abuse, who said she had already reprimanded V13 a week earlier on another similar issue.

V13's personnel file documents V13 was interviewed on 10/11/19 and disciplined for the witnessed incident (10/6/19) and admitted "She did cuss, and that she shouldn't have."

On 10/23/19 at 3:10pm, V13 stated "(R2) was being very rude to me. I (loudly) told her to quit treating me like s**t. This happened in the hall and her room."

On 10/23/19 at 3:40pm, V2 stated she did not feel this was verbal abuse as V13 did not say "quit treating me like s**t" to R2's face.

I (V9) asked (V2) if (V13) needed removed from the building and (V2) said that technically she should come in to handle it, but to do it right she was going wait until (V13) came in the next day on her day off. I left a message for (V1), and I never heard back from him. I never spoke with V1 or V2 about it again. They never interviewed me. V13 continued working that night."

V13's personnel file documents V13 received a written warning on 5/9/19 for "verbal outbursts," and documented "If this or any other unprofessional behavior is witnessed including cussing in public areas, employee (V13) will be terminated on the spot." V13's file documents V13 was interviewed on 10/11/19 about the incident on 10/6/19, and V13 admitted "that she did cuss, and that she shouldn't have."

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S9999	Continued From page 15	S9999		

The facility's 2019 Payroll #22 and #23 document V13 worked the following dates and had access to all residents: 10/6/19, 10/8/19, 10/9/19, 10/10/19, 10/17/19, 10/18/19, 10/20/19, 10/22/19, 10/23/19, 10/24/19, 10/26/19, 10/27/19, 10/28/19. On 10/30/19 at 1:40pm, V2, DON, confirmed the dates/schedule V13 worked. V2 stated CNAs on both halls assist each other during breaks and meals so V13 could potentially care for all residents in the facility.

On 10/23/19 V1 and V2 were unable to provide documentation of notification of the alleged verbal abuse to the State Agency or an investigation for this incident.

On 10/24/19 at 12:10pm, V1, Administrator, stated he did not remember if he was notified of the verbal allegation of abuse on 10/6/19, no abuse investigation was initiated for this incident, and V13 was not suspended pending an investigation. V1 stated this was not verbal abuse because (V13) said it in the hallway, as she was leaving R2's room, not directly facing R2.

3. R3's MDS assessment dated 8/12/19 documents R3 is cognitively intact and documents no behaviors. R3's current care plan documents R3 may refuse care at times and want specific staff to care for her.

R3's Nursing Progress Notes document on 9/25/19 at 4:46am, R3 reported to V15, Certified Nursing Assistant (CNAs) "the horrible way I am treated" by certain staff.

On 10/22/19 at 2:32pm V15, CNA, stated that on 9/25/19, R3 told V15 she (R3) was being bullied by V16, CNA. V15 stated R3 reported R3 could

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S9999	Continued From page 16	S9999		

hear V16 talking about her out in the hall outside her room and that she didn't feel safe here (at the facility) and would rather die than live like this. V15 stated she reported the allegation to V8, Registered Nurse (RN), and witnessed V8 immediately called V1, Administrator, and V2, Director of Nursing (DON), and leave voice mails for V1 and V2. V15 stated "no one called to interview me, so I called (the facility) on Friday morning to see if V1 and V2 got the message. I was told they did and that they interviewed R3. I asked if they needed to talk to me and they said no."

R3's Progress Notes dated 9/25/19 written by V8, RN, document the following: "Immediate VM (voice mail) left for the DON and administrator called, left VM on office phone and called personal phone."

On 10/22/19 at 12:50pm, V2, Director of Nursing (DON), stated "I wasn't made aware of the incident until 9/26/19 (the next day), and I felt it was a behavior because R3 doesn't like to be cared for by ((Certified Nursing Assistants (CNA) with a different sexual orientation)). I have directed that V16, CNA, not care for R3 because of this. V16 answered a call light and knew she wasn't to care for R3, so she went to get someone else to care for her. I did not consider this an allegation of abuse, I did not interview other staff and residents. I considered this a behavior. I was not aware that (R3) had said she was treated horribly, that she had named staff and given examples of the 'horrible' treatment."

On 10/22/19 at 12:55pm, V1, Administrator, stated he was not notified of R3's statements/allegations on 9/25/19, but he should have been notified immediately. V1 stated no

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S9999	Continued From page 17 investigation was initiated, no report sent to the State Agency, and V16, the alleged perpetrator, was not immediately removed from resident contact. The facility's 2019 Payroll #22 and #23 document V16, CNA, worked the following dates and had access to all residents: 9/25/19, 9/26/19, 9/28/19. 10/1/19, 10/2/19, 10/3/19, 10/4/19, 10/7/19, 10/8/19, 10/9/19, 10/10/19, 10/12/19, 10/13/19, 10/15/19, 10/16/19, 10/17/19, 10/18/19, 10/21/19, 10/22/19, 10/23/19, 10/24/19, 10/28/19, 10/29/19, 10/30/19. V2 stated CNAs on both halls assist each other during breaks and meals so V16 could potentially care for all residents in the facility. On 10/23/19 V1 and V2 were unable to provide evidence of reporting or an investigation for this incident. (A)	S9999		