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S 000	Initial Comments Original investigation of Complaint #1925265/IL00114088 and #1925510/IL00114349	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.510 e) 300.610 a) 300.625 b)o) 300.3240 c)d)f) Section 300.510 Administrator e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. 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 300.625 Identified Offenders	S9999	**Attachment A** **Statement of Licensure Violations**	

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b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.
o) Incident reports shall be submitted to the Division of Long-Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility shall identify whether the incident involves substance abuse, aggressive behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.

Section 300.3240 Abuse and Neglect
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)
f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible

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evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These regulations are not met as evidenced by:
Based on observation, interview, and record review, the facility administrator lacked the knowledge regarding the regulatory definition of abuse, which led to the failure to ensure policies and procedures of abuse were followed when abuse occurred on a locked dementia unit, and the administrator hindered the fact finding process by instructing staff to omit information concerning acts of abuse; the facility failed to ensure that six of 12 residents (R2, R3, R4, R6, R7 and R8) in the sample of 12 were free from physical, verbal, and mental abuse; the facility failed to ensure all 11 residents in the locked dementia unit where R1 resided were protected from further abuse during the investigations; the facility failed to conduct thorough investigations for at least five separate incidents of alleged physical or verbal abuse; and the facility failed to ensure the safety of its residents pending fingerprint-based checks of a known identified offender.

Findings include:
R1's (State) Police Criminal History Record, dated May 7, 2019, documents, "Aggravated Domestic Battery with Bodily Harm and Interference with Reporting Domestic Violence. Committed to Special Facility (prison)."

R1's Pre-Admission Information form, dated

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(Anticipated Admission Date) May 8, 2019 documents, "Late Onset Alzheimer's with Behavioral Disturbances." This same form documents, "Alert, Forgetful, Speaks Normally, Combative, Verbally and Physically (abusive), Behaviors."

R1's Face Sheet documents that R1 was admitted to the facility's locked dementia unit on 5/8/19 with the following diagnoses: Alzheimer's and Restlessness and Agitation.

R1's Progress Notes, dated 5/9/19, document, "(R1) has HX (history) of physical aggression."

R1's medical record shows no documentation that interventions were put into place to address R1's criminal background, or R1's restlessness and agitation when R1 was admitted to the facility's locked dementia unit.

The locked dementia unit consists of a straight hall with a nurses room, a storage room, a medication room and a beauty shop room on the left side beyond the locked doors with an open activity room/dining room across from these rooms. Beyond the double doors are 11 resident rooms, one of which is private and ten are double resident rooms.

R1's Progress Notes, dated 5/13/19 at 12:02 P.M., documents, "Resident verbally sing (ing) curse words at another resident. Yelling. (R1) interlocked arms with another resident and spoke about fighting the other resident. Yelling and cursing. Separated residents."

The facility Incident Report, dated 5/14/19 at 12:30 P.M., documents, "Staff report that dementia resident (R1) was aggressive towards

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dementia resident (R3). It was reported there was yelling in residents' room. Staff noted (R3) was on the floor with (R1) hovering over (R3). (R3) was noted to have an abrasion on (R3's) right arm and bottom lip. Vitals obtained by nurse. Physician and Families notified. Administrator (V1) and DON (V2) notified. Well being checks on both parties initiated. R1 moved to (another room on the unit)." This same report documents, "Conclusion: It was reported from witnesses that there was yelling in residents' room (R1 and R3). Upon entering room, (R3) was on floor with (R1) hovering over (R3), residents were immediately separated. (R3) was moved to another room on the unit. Well being checks have identified increased aggressive behavior from (R1), none for (R3). (Psychiatric Services) NP (Nurse Practitioner) has been notified."

R1's Progress Notes, dated 5/14/19 at 1:08 P.M., documents, "(R1) was observed in (R2's) room. (R1) had (R2) by the foot. Released when confronted by staff. (R1) removed from room."

R1's Progress Notes, dated 5/19/19 at 4:39 A.M., documents, "(R1) awake and ambulating into dining room. (R1) immediately starts antagonizing another (unidentified) resident (R7), mocking him, attempting to hit him and swearing at him. When staff intervened, (R1) hit, slapped and choked staff. (R1) was attempting to go into another resident's room. When staff would ask (R1) to leave the room, (R1) would attempt to keep entering the room and attempt to get resident out of bed. Then (R1) would yell and curse at resident. (R1) would lunge at staff and bruised staff's arms and wrists. Police called to intervene and removed (R1) from staff's back as (R1) was pulling her hair."

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R1's Progress Notes, dated 5/21/19 at 7:30 P.M., documents, "(R1) observed in hallway on unit holding onto (R4's) wrists and saying to (R4) get out of here before I kill you. Residents were immediately separated and assessed by nurse. No injuries involved to either resident. (R1) placed on frequent checks. Will continue to assess."

R1's Progress Notes, dated 5/27/19 at 11:34 A.M., documents, "CNA reported that (R1) and (R2) were in an altercation. (R1) had hold of (R2's) left arm. Residents separated, each resident assessed. (V1) notified."

R1's Progress Notes, dated 5/27/19 at 9:03 P.M., documents, "(R1) agitated, attempted to grab another (unidentified) resident (R8). (R1) twisting and pulling staff's arm, threatening to break arm. (R1) came up behind staff and grabbed staff by the back of the head and started to squeeze, threatening to break staff's face. Police called."

R1s Progress Notes, dated 5/31/2019 at 3:17 P.M., "(R1) hostile, swinging at staff. Several staff members attempted to show (R1) to (R1's) room or commons area. (R1) grabbing this nurses hands tightly, attempting to knee this nurse in stomach."

R1's Progress Notes, dated 7/7/19 at 11:23 A.M., documents, "Staff stated that (R1) had hold of (R2) and was not wanting to let go. She was distraught and crying afterwards."

R1's Progress Notes, dated 7/13/19 at 4:10 P.M., documents, "Agitated, violent towards (R4). Redirected other residents to safe places."

R1's Progress Notes, dated 7/14/19 at 1:30 P.M.,

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documents, "(R1) wandering, physically aggressive (with R2), verbally aggressive, hitting staff, raising fists at staff and other residents."

R1's Progress Notes, dated 7/18/19 at 7:45 P.M., documents, "Informed of an altercation between (R1) and (V4) Licensed Practical Nurse where (R1) was escorted out of the facility in handcuffs and the (V4) was taken to the ER (Emergency Room) via ambulance."

On 7/20/19 at 9:00 A.M., V3/Certified Nursing Assistant (CNA) stated, "We have told (V1/Administrator) about (R1) being mean to the other residents, but nothing gets done. Everybody is afraid of losing their jobs. We have been told by (V1) that if we discuss all of these things about (R1) that we would be putting the facility at risk, because they didn't document all of them."

On 7/20/19 at 11:02 A.M., V6/Certified Nursing Assistant stated, "(V1/Administrator) has never had me give a statement about any of the incidents of violence I have seen (R1) do to residents or other staff. I have witnessed him assault (R2) many times. I am scared to be seen talking to you. I don't want to lose my job. I have been told not to discuss this with you by (V1)."

On 7/20/19 at 12:20 P.M., V5/Certified Nursing Assistant stated, " I have never been asked about any of these times or asked to write a statement (for an abuse investigation). I'm scared to talk to you. I don't want to lose my job. (V1/Administrator) has told us to tell you we don't know anything or else the facility would be in trouble."

On 7/20/19 at 12:04 P.M., V5/Certified Nursing Assistant stated, "(R1) has been aggressive since

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(R1) came here. (R1) scares me. One time (R1) threw me up against the wall and said you are going to die. On the night of (7/18/19) when (V4) Licensed Practical Nurse got hurt, I was working with (V6) Certified Nursing Assistant. (R1) was agitated all night, picking on other residents and being intimidating to them. We finally had to call (V4) down to walk with (R1). Me and (V6) were putting another resident to bed and we heard pounding. (V6) ran to (R1's) room and screamed for me. I ran into (R1)'s room and (V4) was passed out on the bathroom floor and (V6) was holding (R1) down on the bed. I called 9-1-1 and then tried to help (V4). (V4) would come to, then pass out again. (V4) looked like (V4) was having seizures. It was the most awful thing I have ever seen. I can't stop thinking about it. I really do believe (R1) would have killed (V4). "

On 7/22/19 at 9:15 A.M., V9/Admissions Director stated, "(R1) was admitted from (a local nursing facility) because (R1) had a history of wandering and (R1) needed a locked unit. We knew (R1) had a history of aggression and agitation."

On 7/22/19 at 9:46 A.M., V10/Social Services Director stated, " (R1) was admitted here on May 8th from another home. I ran (R1's) background check on May 7th and it came back with a 'Hit' for aggravated domestic battery. I know (R1) had spent some time in prison for this. We didn't get (R1) fingerprinted until May 28th. (R1) was admitted to C-Hall and shared a room when he first came in with (R3). We knew (R1) could be aggressive when we admitted (R1), but hoped (R1) would calm down on the locked unit." At that same time, V10/Social Services Director verified that no interventions to address R1's criminal background history or restlessness and agitation were put into place when R1 was admitted to the

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facility.

On 7/22/19 at 10:30 A.M., V11/Licensed Practical Nurse stated, "On (7/7/19) (R1) had been following (R2) around. (V16) Certified Nursing Assistant (former employee) and (V17) Activity Assistant (former employee) heard (R2) screaming and found (R1) in the hallway and (R1) had hold of (R2's) shoulders and had (R2) pinned up against the wall. They had to physically remove (R1's) hands from (R2). (R1) wasn't going to let go."

On 7/23/19 at 9:05 A.M., V11/Licensed Practical Nurse stated, "On July 7th (7/7/19), (R1) had been following (R2) around. (V13) Certified Nursing Assistant and (V14) Activity Aide heard (R2) screaming and found (R1) had (R2's) shoulders pinned up against the wall. The CNAs separated them. (R2) was crying and was upset. I called (V1) Administrator and reported it. (V1) did not tell me to do an abuse investigation."

On 7/23/19 at 9:35 A.M., V1/Administrator stated, "I am the (facility) abuse coordinator." V1/Administrator also stated, " I did not do an abuse investigation into all of (R1's) physical abuse towards other resident's (R2, R3 and R4). I thought (R1) was having behaviors. I did not think it was abuse. The incident on May 13th I felt was just (R1's)behaviors. I looked at the cameras for the incident on May 27th, but I couldn't see (R1) and (R2) clearly. There weren't any injuries, so I didn't investigate it as abuse. I thought it was just (R1) having behaviors. I was notified of the incident between (R2) and (R1) on July 7th; I figured it was just another behavior of (R1). I can't remember if the nurse notified me of (R1) being physical with residents on May 13th and May 14th. If (V14) said she did, then I don't have an

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investigation for those days. I did not report them to your agency."

On 7/23/19 at 10:53 A.M., V18/ R6's son stated, "I've seen (R1) on many occasions when I come to visit (R6). (R1) is a tall, intimidating (person). (R1) wanders around, mumbling to himself, kind of like (R1's) looking for a fight. There was one incident, a week or so ago when I came to visit (R6). (R6) had just finished eating (R6's) lunch, so I pushed (R6) back to (R6's) room. (R1) kept walking by (R6's) room and looking in. (R1) looked real threatening. After awhile (R1) came into (R6's) room and I told (R1) to get out. (R1) turned towards me like (R1) was going to start something, but right then a nurse came into the room and literally had to pull (R1) out. Then it got very scary, (R1) kept trying to kick at the nurse and was yelling and cussing at her. I was very concerned about my mother's safety. I even sent a message to (V1) Administrator to call me about it, but (V1) never called me back."

On 7/24/19 at 8:45 A.M., V13/Registered Nurse stated, "On May 13th, (R1) had (R2's) arms restrained and was yelling and cussing and said (R1) was going to beat (R2) up."

On 7/24/19 at 9:02 A.M., V14/Registered Nurse stated, "On July 13th, (R1) had (R4's) arms pinned down and was yelling and cursing at (R4). I was afraid (R1) was going to hurt him. I brought (R4) out of the unit and had (R4) sit in a chair at the nurse's station. (R4) was visibly shaken, but calmed down once I got him away from (R1). On the 14th (May 14, 2019) (R1) was once again fixated on (R2). (R1) would stalk (R2), like (R1) was trying to corner (R2). (R1) had (R2) by the arm and I had to physically break it up. (R1) was really angry that day, throwing chairs and trying to

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push the tables against people. I finally called (R1's) doctor and said we have to do something else, (R1's) getting worse and (R1) is going to hurt someone."

On 7/24/19 at 11:10 A.M., V15/ R2's daughter stated, "(R2) would have been terrified having (R2's) arms restrained and being held up against the wall. I'm sure (R2) was very upset being treated that way. (R2) can't protect herself. Violence of any kind, scared (R2)."

On 7/25/19 at 11:43 A.M., V4/Licensed Practical Nurse (LPN) had bruises covering both wrists extending up the arm, approximately 4 inches on each side. A prominent contusion was visible to V4's left forehead. Bilateral discoloration was present under both of V4's eyes. At that time, V4/LPN stated, " (V2) Director of Nurses begged (V1) Administrator not to admit (R1). We knew (R1's) background. We knew he used to beat (V19) spouse. But (V1) admitted (R1) anyway. (R1) was violent from the time (R1) was admitted and it just escalated. I can't remember which resident (R1) went after on the night of May nineteenth. It was a male resident. The night (R1) choked me, the other nurse (V7) Licensed Practical Nurse was running late, so I was the only nurse in the building. The two CNAs (V5 and V6) on the locked unit kept calling me because (R1) was acting up. I went down to the unit and (R1) was very agitated, so I walked with (R1). (R1) had hold of my wrists tightly and wouldn't let them go. I was just walking backwards with (R1) and talking calmly to get (R1) to calm down. At one point I thought I would take (R1) out in the courtyard and I opened the door. Evidently (R1) didn't want to go because (R1) yanked me back inside. (R2) was there too and I was trying to place myself in front of (R2) to protect (R2). I

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asked (R1) if (R1) needed the toilet and (R1) said yes. I was happy to get (R1) out of the hallway, the other residents were watching all of this and they were so upset. When I took (R1) in the bathroom, there was feces on the toilet seat, so I put on a pair of gloves and cleaned it so (R1) could sit down. I turned my back for just a minute to wash my hands and when I turned back, (R1) smashed me in the nose with a plastic soap bottle. It hurt so bad. At that time, (R1) grabbed me by the hair and slammed my head repeatedly into the door frame. I kept trying to open the door between the rooms so I could get away. I forgot they locked that door so (R1) couldn't get to the resident in that room. I was stuck. The last thing I remember is (R1) grabbed the stethoscope around my neck and choked me. I woke up on the bathroom floor and someone was trying to get my vitals. When the residents on the unit saw me on when I came back to work, some of them were crying. They were so upset at what (R1) did to me. They said they feel so bad that they couldn't protect me from (R1)."

On 7/25/19 at 11:43 A.M. V4/Licensed Practical Nurse (LPN) had bruises covering both wrists extending up the arm, approximately 4 inches on each side. A prominent contusion was visible to V4's left forehead. Bilateral discoloration was present under both of V4's eyes. At that time, V4/Licensed Practical Nurse stated, "Am I in trouble. (V1/Administrator) keeps telling me that I am the reason you are here and the facility is going to get into a lot of trouble if I tell you the truth. We have been told so many times not to chart certain things that will get us in trouble, by (V1). One time, (V1) even erased the charting I did in a resident's chart because (V1) said it was too damaging for the facility. (V1) would come down to the nurse's station and tell us what to

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	IL6001374	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER NURSING & REHAB CENTER	516 WEST FRECH STREET STREATOR, IL 61364

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chart in the resident's chart. A couple of days after an incident involving (R1) and (R2), I was told in report that (R1) had choked (R2) into the ground. (V1) wouldn't let (R2) go to the hospital, but the next day (R2) was totally non-responsive in bed. The nurse was told not to chart anything about it. (V2/Director of Nurses) begged (V1) not to admit (R1). (V1) even came up to the hospital ER (Emergency Room) (after the incident of 7/18/19) and came into my room, even after they told (V1) not to. (V1) kept telling me all I had was a panic attack. I was physically assaulted. Now (V1) is telling me I better not tell you everything or the facility is going to be in trouble. They said you are here because of me."
"I wasn't the assigned nurse for (the unit) on May 14th. Around 1:08 P.M., I happened to be walking by (R2's) room and I saw (R2) sitting on the bed and (R1) leaning over and holding (R2) by the foot. I wasn't sure what was going on, but I was concerned that (R1) had ahold of (R2) like that. I was able to talk (R1) into coming out of the room with me. That's all I did, was take (R1) out of the room. I didn't report it to anyone, I charted it."

The (undated) facility policy, Identified Offender Facility Policy and Procedure, directs staff, "Upon admission of an identified offender or the decision to retain an identified offender, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. The facility shall incorporate the identified offender report and recommendations report into the identified offenders plan of care including the security measures listed."

The facility abuse policy, Abuse Prevention Program, dated (revised) 01/2019, documents, "Employees are required to immediately report

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any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the administrator if available or an immediate supervisor who must immediately report it to the administrator. Upon learning of the report, the administrator or in the absence of the administrator, the DON (Director of Nurses) shall initiate an incident investigation. (Definitions) Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, psychological well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Any incident, or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation."

The (facility) Administrator Job Description (undated) describes the job duties of the facility administrator as, "The administrator leads and directs the overall operation of the facility in accordance with resident needs, federal and state government regulations. Demonstrates knowledge of all (State) Department of Public Health rules and regulations and provides adequate instruction regarding such rules and regulations to appropriate staff."

(A)