

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
---	--

(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
--------------------	--	---------------	---	--------------------

S 000	Initial Comments Licensure Investigation Complaint 2075256/IL124518.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.3240b) 300.3240e) Section 300.3240 Abuse and Neglect 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) 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. (Section 3-611 of the Act) This REGULATION was not met as evidenced by: Based on interview and record review, the facility failed to suspend an employee following an allegation of abuse and ensure the employee did not have contact with residents until a full investigation into the allegation could be completed. The facility also failed to ensure a resident's allegation of abuse by an employee	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
---	--

(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 1 S9999

was reported to the abuse coordinator per the facility policy.

This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3.

The findings include:

The EMR (Electronic Medical Record) shows R1 was admitted to the facility in November 2017. R1 has multiple diagnoses including urinary tract infection, COPD (Chronic Obstructive Pulmonary Disease), altered mental status, anemia, heart disease, anxiety, cardiomyopathy, dysphagia, dementia, major depressive disorder with psychotic symptoms, cognitive communication deficit, difficulty walking, pain, and spinal stenosis.

The EMR shows R1 was transported from the facility to the local hospital on June 26, 2020. R1 did not return to the facility and no longer resides at the facility.

R1's MDS (Minimum Data Set) dated May 30, 2020 shows R1 had moderate cognitive impairment, required extensive assistance for bed mobility and transferring between surfaces, dressing and toilet assistance. R1 was totally dependent on facility staff for bathing. R1 had limited range of motion on one side of her upper extremities. R1 had urinary and bowel incontinence.

R1's care plans were reviewed. R1's care plan dated May 24, 2020 shows R1 has attention seeking behaviors/delusions as evidenced by reporting false allegations about staff mistreating her. Interventions dated May 24, 2020 include, "Staff will provide care in pairs."

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
---	--

(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 2 S9999

On July 2, 2020 at 11:42 AM, V6 (Daughter/POA-Power of Attorney) said, "I am the POA for [R1]. On June 24, 2020, [R1] had stayed awake a little later than usual, and she was on the phone with me, and she needed to be changed so she called the aide to help her, and she said she would call me back when the aide was finished. She called me back about 30 minutes later, and she said the aide had hurt her. [R1] said she had her phone in her hand and the aide turned off the light and forcibly took the phone out of [R1's] hands. [V4] (RN-Registered Nurse) got [R1's] phone back so she could call me back. [V4] told me she called the administrator to notify him of the incident and that the aide would not take care of my mother anymore that night. I was not told the name of the aide."

On July 2, 2020 at 12:04 PM, V3 (CNA-Certified Nursing Assistant) said, "On June 24, 2020 around 10:30 PM, I walked into my shift and [R1] had her call light on. I went in to see what she wanted, and she said she wanted to be changed. I started changing her. She needs assistance to roll to her side. I helped her, and she complained that I was hurting her. She said, "My back hurts, and you are hurting me." She has her own personal cell phone and it was on her bedside. She tipped the bedside table on me, and she said I threw her phone across the room. She tried hitting me while I was changing her. [V4] (RN) came into the room, and the resident told the nurse that I hit her. She said I was hurting her. The resident said I hit her, and I choked her with the cord. I worked the rest of my shift but did not care for [R1] anymore that night."

V3's Time Card Report dated June 20, 2020 to July 2, 2020 shows V3 punched in for her shift at 10:05 PM on June 24, 2020 and punched out at

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
---	--

(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
5:52 AM on June 25, 2020.

On July 2, 2020 at 12:39 PM, V4 (RN) said, "We were getting report and it was 11:00 PM and [V3] (CNA-Certified Nursing Assistant) came to me and she said she didn't know what was wrong with [R1] because she was combative. We interrupted report and I went in the room, and [R1] was saying, 'Call the police, call the police', and she pointed to her hand where she had a small bruise. She kept saying 'The woman did it.' I handed her the cell phone. It was not within her reach. The phone was on the bedside table, almost at the foot of the bed. I asked [V3] (CNA) why it was out of her reach and she said she was afraid that [R1] was going to call the police. [R1] called her daughter after I gave her the telephone. I told [V6] (Daughter/POA) the resident had a bruise on her hand and according to the CNA, the resident was combative. [R1] kept saying, 'The woman did it, the woman did it.' The resident knows [V3] (CNA) very well. I don't understand why she became combative. I called [V5] (Assistant Administrator). He told me to make sure the [V3] (CNA) didn't take care of the resident anymore. He said he would look into it. [V3] (CNA) did work the rest of the night as far as I know. I left after that, but the communication between me and the other nurse was that she would not enter that room. I measured the bruise on her hand and I think it was 1.0 cm x 1.5 cm. I told [V6] (Daughter/POA) the resident was claiming that someone did this to her. No other females had been in the room."

On July 6, 2020 at 10:49 AM, V7 (LPN-Licensed Practical Nurse) said, "I took care of [R1] on June 25, 2020. I remember seeing bruising on her hands. When I started my shift that day, they told me there was a bruise on her hand. They said

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
--	--

(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

she was saying that someone had done that to her. When I did my rounds that morning, I went in there and assessed her and I asked her if she was in any pain. She had a bruise on her hand from her middle finger down to her pinkie, and it was pretty swollen. I asked her if she could move her fingers and I asked if she wanted pain medicine. I called the nurse practitioner and told her that her hand was looking kind of bad. I asked for an order for an x-ray STAT. The resident did say that someone did this to her. She said, 'That lady or that woman or that man did that to her. They kept coming in and shutting the door on me.' and I was told in report that was her claim from the beginning. I wasn't told this was being investigated. I did document in the nurse's notes the resident was making the allegation, but I did not report the allegation to the administrator or anyone else."

V7's (LPN) documentation dated June 25, 2020 at 1:24 PM shows: "Resident complaining of pain to her left hand. Swelling and bruising to left hand from middle finger to pinky near the knuckle and top of hand. Resident would not let writer even touch it. Resident states "that woman who kept coming in and out did this." Resident also was referring to the children who were in her room. NP made aware, x-ray ordered STAT."

The facility's undated initial Incident Report Form shows: "Reportable Event Occurred on: Date: 6/26/2020 Time: 9:30 PM." The incident allegedly involved R1 and V3 (CNA). Facility documentation shows the facility reported the incident to IDPH (Illinois Department of Public Health) on June 26, 2020 at 11:33 PM.

The facility's undated final Incident Report Form shows: "Reportable Event Occurred on: Date:

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
--	--

(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

6/26/2020 Time: 9:30 PM." The incident allegedly involved R1 and V3 (CNA). The description of occurrence shows: "R1 alleged that a staff member provided care that is inconsistent with facility standards. The family and physician were notified. Staff member suspended pending investigation. Skin and body assessment was conducted, staff noted left middle finger bruising measuring 1.5 cm. x 1 cm. Investigation: "While R1 was admitted to [local hospital] on 6/26/20 with diagnosis of bilateral hip pain. R1 stated to hospital staff that "aide at nursing home assaulted her."

Hospital documentation dated June 26, 2020 by V8 (RN) shows: "Nursing progress note: [R1] states that she was assaulted yesterday while at the [facility]. Patient states that she was in her room with her cell phone in her hand when a healthcare worker came in the room and tried to take the phone away from her. Patient does not know the name of the healthcare worker or what position she has at the rehab center. Patient states that the worker ripped the phone out of her left hand and twisted her fingers while stating "I'm gonna break all of your fingers." Patient then states the worker tried to wrap the call light cord around her neck but was unsuccessful because she was able to fight her off. Then the worker pushed her onto the bed. At this point, another worker, [V4] (RN), came into the room and the other worker ran off. Patient was helped back into bed and given her phone back. ...Patient has bruising to left hand that looks new and a small bruise noted on right hand. No other bruising, new or old, noted on the patient at this time. Daughter is currently with patient at this time in the hospital. Daughter states that she has been trying to find out the name of the healthcare worker who was involved but that the staff and

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
---	--

(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 6 S9999

administrators won't release any names. Patient also has a history of dementia but is alert and oriented to person, place, and time. 2021 (8:21 PM) Called [facility] to get some more information about the situation. Spoke with [V5] (Assistant Administrator), one of the administrators for the facility. [V5] stated that patient and daughter have a history of making abuse allegations towards staff members, about 1 a month. [V5] stated that a report has been made so an investigation is ongoing at this time. He also stated that she has a history of fighting/hitting the staff due to her dementia."

On July 6, 2020 at 2:58 PM, V2 (DON-Director of Nursing) said, "I dated the abuse allegation as June 26, 2020 because that was when I did the initial investigation. June 26, 2020 was the day the local hospital reported the abuse allegation to us. The incident happened on June 24, 2020. No one at the facility had reported the resident's allegation of abuse to me or [V5] (Assistant Administrator). The staff should call the administrator or myself if there is an allegation of abuse. This needs to be reported immediately. The hospital told me the staff was abusive with [R1]. I was not aware of any documentation in the medical record by [V7] (LPN) showing the resident alleged abuse on June 25, 2020."

On July 6, 2020 at 3:58 PM, V5 (Assistant Administrator) said V3 was not suspended on June 24, 2020 because he saw the situation as a "customer service issue." V5 said he was not aware of the allegation of abuse until reported by the local hospital on June 26, 2020. V5 said he was not aware V7 (LPN) had nursing documentation dated June 25, 2020 showing R1 had alleged abuse. V5 also said he did not know why V5 (CNA) did not follow care plan

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
---	--

(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	<p>Continued From page 7</p> <p>recommendations to work with another staff member while caring for R1. "I know in the past, with [R1's] allegations of abuse, that we decided to always have a witness there, as well as when someone was taking care of her."</p> <p>The facility's Abuse Prevention Policy, dated February 2017 shows:</p> <p>"V. Internal Reporting Requirements and Identification of Allegations.</p> <p>Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.</p> <p>Reports will be documented, and a record kept of the documentation.</p> <p>Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.</p> <p>VI. Protection of Residents</p> <p>Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LEMONT NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12450 WALKER ROAD LEMONT, IL 60439
--	--

(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

misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated."

(C)