STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003644	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NILES NSG & REHAB CTR	9777 GREENWOOD NILES, IL 60714

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S 000	Initial Comments Complaint: 2193244/IL133795 - F600 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.3240a) 300.3240b) 300.3240d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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) 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) These Regulations were not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interviews and record reviews, the facility failed to keep a resident free from experiencing verbal aggression from staff (V3, certified nursing assistance). This applies to one resident (R3) observed receiving verbal aggression by staff. As a result, R3 expressed feeling unsafe in the facility, feeling intimidated and threatened. Findings Include: R3 is a 59 year old male with diagnoses of Malignant Neoplasm of Meninges; Hemiplegia; Cerebral edema, Hypertension and depression. On 7/12/2021 at 2:00pm, surveyor observed R3 had his call light on. Surveyor and V5 RN (Registered Nurse) entered into R3's room. R3 stated he had his light on because he wanted a shower. As V5 was answering R3, V3 CNA (Certified nursing assistant) cut her off in a loud and aggressive tone of voice said, "they told me you can only get a shower once a week." R3 leaned back on his bed with a blank stare on his face. V3 CNA and V5 RN left the room, Surveyor asked R3 if this is V3's usual behavior? R3 said: Sometimes. R3's roommate (R4) said, "Yes, V3 told me I needed to be quiet this morning." On 7/13/2021 at 12:21pm, V3 CNA was interviewed regarding incident with R3. V3 stated "He at first wants his clothes changed earlier, then asked if he could have shower. I told him that his shower is tomorrow and we were short staffed yesterday. I have been a CNA (Certified Nurse Aide) for four months. I tend to float around the facility. R3 just moved to the floor. I know him but he has a behavior. We get along pretty well. He would just pull his call light to talk with the head of the building when we already told him	S9999		

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S9999	Continued From page 3 they are not in the building, he makes up stories. Usually, he works with me pretty well. Yesterday, I walked into the room and R3 was asking about a shower. I was trying to explain to the state lady that R3 takes showers once a week on the morning shift. R3 is supposed to get a shower twice a week - one in the morning and one on the other shift. R3 is known to have behaviors. We are all aware of that with him, you have to be straight forward. You can't take what the resident says serious all the time. He would tell me he has not been changed in a week and I know I changed him in the morning. As far as I am concerned, there was no incident that happened yesterday. I did not talk to R3 but to the State lady. I did not do any verbal aggression on the resident, V5 RN was there." V3 CNA was asked regarding knowledge on the facility abuse policy. V3 said, "I had a long orientation for abuse when I started. I don't know who the Abuse Coordinator is but I do have it written down somewhere." On 7/13/2021 at 1:17pm, R3 was asked regarding the incident between R3 and V3. R3 stated, "I don't feel safe here, they stand over you trying to intimidate you, they talk to you like you are garbage, and they don't respect you. I feel scared I don't want to be here. V3 is a stern person, I don't know what was wrong with her yesterday, she sounds scary. On 7/14/2021 at 1:32pm, Interview with V5 (Registered nurse) stated "I was helping R3 make coffee that morning when he asked if he could change his clothes. I told R3 they will change him between breakfasts and lunch at 2:00pm. R3 put his call light on and asked about his shower. V3 said she already changed his clothes. No, I don't think it was appropriate the way V3 CNA addressed R3. I told V3 that she needed to go to	S9999		

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S9999	Continued From page 4 the nursing office and she left and went home without telling me. I talked to V18 Assistant Director of Nursing (ADON) verbally but I did not do the form. The last in-service on abuse was not long ago. Physical, verbal, sexually and chemical. You are supposed to talk to your supervisor and they will do an investigation and send you home. If I see it, I have to report it. V3 was talking in a loud voice when she tried to explain to the resident about his shower. She looked mad because it was close to the end of the day and was trying to finish up rounds before the end of the shift. I would have just listened to the resident and then try to explain in a calm manner about the shower. No, she didn't do that she was loud and mad". On 7/13/2021 at 3:48 PM, V2 (Director of nursing) was interviewed regarding abuse. V2 stated, "I do the abuse in-services per facility policy quarterly, every 6 months or as needed. This month, I did two in-services on abuse. The administrator is normally the one who does the abuse in-services, he educates them on the types of abuse, who is the abuse coordinator, and who they should report to the chain of command. We have sign in sheets and if any staff is missing the administrator will let me know. After hiring staff, the administrator does an in-service on abuse and social services does an in-service on resident rights." On 7/14/2021 at 4:31pm, V17 (Psychologist Nurse Practitioner) was asked regarding R3. V17 stated, "I have seen R3 twice since he was admitted, his initial assessment and last June. R3's behavior is sporadic, he can be calm but is easily irritated and can be verbally combative to staff. No, he never hit anyone. He can be uncooperative with staff. I have not seen this	S9999		

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S9999	Continued From page 5 behavior but as far as the progress notes reads, but I have heard him irritated. Verbal abuse can possibly have a negative affect on R3 and cause him to feel afraid and not want to remain here anymore that is possible for him to feel that way. I expect for the staff to treat them as a human being, they are there for a reason because they need some type of help. The staff need to try to have patience with them. Sometimes, I feel like I'm losing my patience with them but I choose the option to walk away. All patients deserve to be treated with respect and like humans." On 7/15/2021 at 12:21pm, interview with V2 Director of Nursing stated "V5 registered nurse reported to V18 Assistant Director of Nursing (ADON) that V3 Certified nursing assistant was verbally inappropriate with R3, and stating he was lying that's not what they said. R3 really has a behavior problem but I always talk to staff in regards to him being here for a reason and regardless of his behavior we should really know how to handle him that's why we do continuous in-services on resident's rights, customer service and abuse. My expectation of my staff no matter what they should not retaliate and they should hold their emotions. Staff are trained when certified to know that sometimes a resident may be aggressive and verbally abusive. Staff should try to remain calm, separate themselves and report it to the supervisor. Staff should never say anything demeaning or disrespectful to the residents". Facility's policy titled, "Abuse Prevention Program" last revised 6/21/2021, documented in part but not limited to the following: Under VII. Protection of the resident states: The facility desires to prevent abuse neglect,	S9999		

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S9999	Continued From page 6 exploitation and misappropriation by establishing a resident-sensitive and resident-secure environment. This will be accomplished by a comprehensive quality management approach. Under VII Protection of the resident bullet number 6 states: On a regular basis, supervisors will monitor the ability of the staff to meet needs of residents; staff understanding of individual resident care needs and situations such as inappropriate language, insensitive handling or impersonal care will be corrected as they occur. Incidents short of willful abuse will be handled through counseling, training and if necessary or repeated, the facility's progressive discipline policy. (B)	S9999		