STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: _____ B. WING _____	C 05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation 2193020/IL133520	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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) These requirements were not met as evidenced by: Based on interview and record review, this facility failed to follow their abuse policy and prevent a facility staff member from twice slapping the face of a resident and wrestling over the call light. This affected 1 of 3 residents (R1) reviewed for abuse. This failure resulted int R1 saying she felt unsafe, badly, and in fear of the staff member who slapped her. Findings include: R1 was admitted with end stage renal disease and dependence on renal dialysis. R1's Minimum Data Set (MDS) section G Functional Status dated 2/2/21 documents: R1 requires extensive of one person physical assist with bed mobility. R1 had a BIMS (Brief Interview for Mental Status) score which indicates moderate impairment. On 5/5/21 at 12:26pm, V5 (Certified Nursing Assistant/CNA) stated, "The call light was on in R1's room. I noticed R1 sliding out of the bed. I hurried to reposition R1 back into the center of the bed. R1 scratched my right arm during the repositioning. I was suspended based on an abuse allegation." On 5/5/21 at 12:33pm, V6 (Director of	S9999		

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S9999	Continued From page 2	S9999		

Nursing/DON) stated, "R1 informed me staff slapped her twice in the face. R1 reported the staff member was wearing green pants and a white flowered top. V5 (CNA) wore green paints and white flowered top."

On 5/5/21 at 12:59pm, R1 was alert and orient to person, place and time for this interview. R1 stated, "The CNA wearing the white top and green pants hit me on both sides of my face with an opened hand. I felt bad."

On 5/5/21 at 3:33pm, V10 (pm Supervisor) stated, "R1 stated 'She hit me in the face twice.' R1 couldn't remember who hit her. I informed V6 (DON) of the allegation. I told V6 that R1 reported wrestling with someone resulting in a fall. V5 was R1's CNA. V5 (CNA) had on a white top and green pants. V5 denied wrestling with or any issues with R1."

On 5/5/21 at 3:57pm, V11 (CNA) stated, "R1 will ask staff to reposition and turn her. I was informed by V4 (Nurse) that R1 had a fall. I picked R1 up off the floor. R1 stated someone hit her."

On 5/6/21 at 12:04p, V12 (Dialysis Nurse) stated, "R1 reported being hit twice in the face by an aide at the facility. R1's right cheek was slightly swollen. I wrote the allegation on the bottom of our dialysis communication form."

On 5/6/21 at 4:30pm, R1 stated, "I put my call light on. I asked V5 (CNA) to turn me on my left side. V5 gave me the bed control so I could reposition myself. V5 told me which buttons to push. I didn't know how to use the bed controller. I grabbed the call light. V5 grabbed the call light as well. We both were pulling on the call light

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S9999	Continued From page 3	S9999		

cord. V5 was trying to take the call light from me. I tried to hold on to the call light but the pulling back and forth was hurting my hand. V5 took the call light from me, hit me in the face and didn't say a word. V5 hit me on both side of my face with an open hand. V5 took the call light and hung it on the wall out of my reach. V5 walked to the door, looked back at me and closed the door. I started calling the nurse. I couldn't reach the call light. I knew the nurse could not hear me with the door closed. I got out of bed and fell to the floor. I was going to crawl to the door for the nurse to hear me. I talked to V6 (DON). V6 told me the CNA didn't hit me. I told V6 she did. I have never complained about being hit by staff. I felt sad, hopeless, bad and unsafe.

On 5/7/21 at 12:57pm, V5 (CNA) stated, "The day I worked with R1, I had on a white top with butterfly print and hunter green pants.

Nursing notes dated 5/4/21 document: At approximately 4:45am, R1 was on floor when entering the room. R1 states she was wrestling with CNA over the call light.

Facility statement dated 5/4/21 documents: R1 states the nurse hit her twice in the face. R1 stated, "I just want you do something about her."

Dialysis communication from dated 5/4/2021 documents: R1 reports she was hit twice by an aide while in the nursing home.

Multidisciplinary Note dated 5/4/2021 documents: Upon arrival, swelling on the right cheek of the face. R1 reports she was hit twice by the aide in the nursing home.

Psychosocial Progress notes from the dialysis

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S9999	Continued From page 4 center dated 5/4/21 document: R1 reports mistreatment at the nursing home. R1 stated, "They stated I can turn myself over; she hung up the call light where I could not reach it. Staff hit me twice. Staff hit me on each cheek." R1's cheek appeared swollen. Facility Incident Report dated 5/4/2021 documents: Individual allegedly involved: R1 and employee: Description of occurrence: R1 alleged that staff member was providing care that is inconsistent with facility standards. Investigation initiated. Abuse Prevention Policy dated 2/2017 documents: This affirms the right of our residents to be free from abuse. Establishing an environment that promotes resident security and prevention of mistreatment. Abuse means any physical or mental injury which results in physical harm or mental anguish to a resident. (B)	S9999		