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	IL6003610	A. BUILDING: _____ B. WING _____	C 05/17/2021

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S 000	Initial Comments Complaint Investigation #2193259/IL133812	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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 requirements are not meet as evidenced by: Based on interview and record review, the facility failed to protect a resident who is dependent on staff for care from abuse by a staff member. The facility also failed to follow their abuse prevention protocols by failing to immediately separate an alleged abuser from the resident and failing to thoroughly investigate the allegations to include potential witnesses and/or other residents under the alleged abuser's care for one (R3) of four residents reviewed for abuse. This failure caused R3 to endure pain, fear, mental duress, and an unplanned early discharge back to home. R3 is an alert and oriented 83-year-old Polish-only speaking resident admitted to the facility on 5/7/21 for therapy services after being hospitalized for a fall at home and fracture of the	S9999		

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right foot bone. R3 has diagnoses of Parkinson's disease, hypertension, and atrial fibrillation. R3's MDS (Minimum Data Set) dated 5/10/21 shows R3 requiring extensive assistance with a 2-person physical assist to transfer from chair to bed.

Nurse's note written by V9 (RN) on 5/12/21 at 5:05 PM stated, "Received patient in wheelchair in stable condition. Noted patient was upset and crying, stated she feels cold, but refused to cover with blanket and agreed to put her shirt on. Noted patient was still upset and stated, "go away from my room". Writer made sure patient was comfortable in wheelchair and call light was within reach, left room. Patient is alert and able to express self in Polish only. At lunch time, Patient transferred to wheelchair and setup tray. Around 1:30 PM, writer heard voice from patient's room that she was crying, but call light was off. CNA went to check on patient and transferred to bed as per request and made comfortable. Around 2:00 PM, writer went to check on patient again, noted patient was resting comfortably in bed and was asking for water. Writer provided ice-water, but no other concern voiced at this time. All needs attended. call light is within reach. will continue to monitor.
5/13/21 at 10:07 AM, surveyor asked V1 if he was the abuse prohibition coordinator and if there were any new allegations of abuse that were reported to him within the last 24 hours, V1 stated, "You must be referring to R3. I was informed by my admissions people who got a call from R3's daughter. V22 (admissions director), who knows Polish, spoke to R3 because she can only speak Polish. I was told that V17(CNA-Certified Nurse's Aide) took over for R3's CNA who was on her lunch break. The resident (R3) told V22 that she was wanted to be put back to bed and that V17 was rushing her

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S9999	Continued From page 3	S9999		

back to bed and accidentally hit her feet with his or something like that. I'm still investigating it now and I sent the initial investigation report to your office. The resident also asked for another pillow and I was told that V17 responded to R3 that she already had 3 pillows, so he initially didn't give her another but eventually he did give her another pillow. Again, I'm still getting some final details about it from my staff, but I do think that it may have something to do with the fact that her (R3) was cut off from therapy." Surveyor asked what he did with the CNA (V17), V1 stated, "Well we pretty much determined there was no abuse, so he continued on with his shift." Surveyor clarified whether V17 was sent home or was allowed back to work, V1 stated, "I pretty much determined there was no abuse here so (V17) is scheduled back tomorrow."

Surveyor asked V1 for copies of the facility-reported incidents sent to the local public health office. Records show on 5/12/21 V1 sent an initial facility reported allegation of abuse involving V17 against R3.

Initial report showed: "Date of alleged incident 5/12/21; Time of alleged incident: Around 12:30 PM. The facility has an allegation that may involve one or more of the following reportable situations: Physical Abuse, Neglect. The individual allegedly committing the offense is: Employee. Alleged victim: (R3) Age: 83. Alleged Victims diagnoses and mental status: Non-displaced fracture of fifth metatarsal bone, right foot, muscle weakness, difficulty walking, Parkinson's disease, pain in right foot, history of falling." V1's wrote: "Administrator spoke with resident's daughter to discuss the concerns she mentioned to admissions team. Resident's daughter scared that a male CNA came in to help

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S9999	Continued From page 4 her and rushed her and threw her on the bed. Daughter stated that he (CNA) hurt her leg and now it is worse than when she got there. She also stated that she has been sitting in her room with no TV because no one cares about her and its "neglect". Daughter stated that she asked for pillows and CNA just tossed them at her bed. Administrator then had admissions who speaks Polish get statement from resident and resident explained that it was an accident, he was just a bit hurried, and no other new pain in her leg area." Report copy provided to surveyor titled "Final Incident Investigation Report Form" Facility reported dated 5/13/21 showed in part (but not limited to): "Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: Abuse, Neglect is Unsubstantiated, as follows (summarize facts obtained during investigation): Based on interview with resident and staff it was determined that there is a large communication barrier that may have led to confusion. Resident speaks polish and does not always understand, what staff are communicating. During interview with resident, resident also that no one intentionally tried to hurt her, but staff seemed to be in a hurry. Staff educated on proper approach to care especially when communication barrier is present. This founded allegation involved an employee. See attached listing of employee's name, address, phone number, title, date of hire, and copies of previous disciplinary actions. This employee is currently: Reinstated. A full head to toe assessment was completed to assess the resident for injury. The resident's physician was notified of the allegation. This constitutes the Final Investigative Report concerning this	S9999		

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S9999	Continued From page 5 allegation. Individual completing the report: (signed by V1), Administrator. " Facility's final incident report included a statement from V22 (Admissions Director) and person who interpreted for R3 and wrote: "I, (V22) Director of Admissions, went to speak with the patient (R3) after her daughter called the admissions department with a couple concerns regarding her mother's care. I went to speak to the patient in Polish her primary language at 4:30 PM on 5/12/21 on what had occurred. She mentioned that a male helper transferred her from wheelchair to the bed and was trying to transfer her quickly when he unintentionally hit her right leg with his leg. She did not claim to be in any additional pain. She expressed that she has Parkinson's and has consistent pain in her arms and legs and needs to be transferred slowly. After the male helper transferred her into bed, she had asked him for another pillow, which was sitting on the recliner, he told her she already has 3 pillows and didn't need anymore. She was begging him for another pillow to put under her arm to keep it elevated. He finally agreed and she stated that he threw the pillow at her." On 5/13/21 at 10:45 AM, surveyor approached V9 (RN) and asked about the incident that had occurred with R3. V9 stated, "I was her nurse yesterday too and around 2:00 yesterday, I was doing my rounds and when I went in to see her she asked me for some ice water and she told me she had pain in her foot after V17 put her back in bed. I was later told by the admissions department (V22) that there was a complaint about abuse from the daughter and so I checked out R3's foot when she complained about it but I didn't really assess her head to toe and I should have." Surveyor asked how R3's demeanor was, V9 stated, "Well she was very upset and crying	S9999		

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S9999	Continued From page 6 and she didn't want me in her room anymore." Surveyor asked if she endorsed to the following nurse what had happened or to monitor R3 further, V9 stated, "The next nurse was an agency nurse and I did not endorse the incident to him and I should have but I don't believe I did." On 5/13/21 at 11:00 AM surveyor interviewed R3 with the assistance of V18 (Occupational Therapist) who interpreted Polish during the interview. Surveyor asked R3 what had happened and R3 appeared visibly upset as she spoke Polish to V18 to answer surveyor's questions. R3 stated, This CNA man (V17) put me back in bed and he was hurrying me up and I can't move fast, I'm old and I'm in pain." Surveyor asked to describe how V17 was hurrying her up, R3 stated, "He was pushing his leg and his foot and kept kicking my foot with his foot to get me moving and he hurt me." Surveyor asked which foot he was kicking, R3 stated, "My right foot." Surveyor asked which foot she had a fracture on, R3 pointed to her right foot. R3 continued, "He (V17) kept telling me "Hurry up! Hurry up! Hurry up! He looked angry and was upset that I was too slow." Surveyor asked how it made her feel, R3 stated, "How else should I feel. I was upset and I was afraid of him." Surveyor asked what else happened, R3 stated, "I also asked him (V17) for another pillow and he pointed to my bed and shouted, you already have 3 pillows!" Surveyor asked how V17's tone was when he stated this, R3 stated, "He was angry like I said, and he didn't want to give me another pillow until I had to beg for one. I just wanted one for under my arm and I was upset that he couldn't just give me another one. He finally did, and he threw it roughly at me." Surveyor asked if she told her nurse right away of what happened, R3 stated, "No because no one here speaks Polish except for her (pointing at	S9999		

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V18). Surveyor asked R3 if the facility provided her with any communication board, R3 stated, "No." V18 searched the room for one but could not find any communication board for R3. R3 stated, "I called my daughter right away and told her what happened so she told me she will get me out of here soon because of what I told her. She talked to me today and said she will take me home today and maybe I will go somewhere else to get therapy. I don't want to stay here anymore either because I'm very afraid to stay here because of that man."

On 5/13/21 at 11:55 AM, interview with V15 (MDS/Nursing Supervisor) stated, "At around 4:30 PM, V2 (DON) called me to go in and see the patient for a concern and V22 came with me because she spoke Polish so she could interpret. We met the patient and she (R3) said at 1:00 PM that a guy who we later found out was (V17) put her back to bed but he was in a hurry and hit her in the right foot. He hit it with his foot with his leg because he was in a hurry, but it was accidental because he told the administrator he was in a hurry. I told R3 I will check her foot and there was no discoloration or bruising. (R3) told me that she had pain, but it was on and off. I told her it looked okay. She also said she requested for a pillow so she could have it under her arm for comfort and (V17) told her she didn't need one because she already had 3 pillows." Surveyor asked if the request for another pillow was honored, V15 stated, "I don't know if he gave her a pillow." Surveyor asked how her demeanor was when she assessed her, V15 stated, "She looked very upset."

On 5/13/21 at 12:45 PM, interview with V22 (Admissions director) stated, "My coworker got a call from R3's daughter. I got involved because I

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can interpret and R3 can only speak Polish. I was told that a CNA transferred R3 from wheelchair to bed and while transferring the CNA's leg made contact with R3's leg. She wasn't in any more pain than normal because she had Parkinson's disease." Surveyor asked her to clarify, V22 stated, "I'm not clinical so I'm just telling you what information I got from nursing." V22 continued, "R3 asked for a pillow and the CNA told her she already had 3 pillows. When I spoke to R3 she said she had to beg for a pillow." Surveyor asked if she was present when V15 assessed R3 for any injuries, V22 stated, "I went up to R3's room a second time because V15 needed an interpreter and I observed V15 take R3's socks off and she looked at her legs and toes and asked her if she was in any pain. She told me it wasn't intentional, but she was very emotional when she was talking to me. She was almost crying in fact and she did appear afraid."

On 5/13/21 at 1:20 PM, interview with V17 (with V23-Spanish interpreter), stated, "I transferred the resident on the bed. I used my gait belt. I told her in English, but she no understands." Surveyor asked if he accidentally stepped on her feet, V17 stated, "No I never touched her." Surveyor went on to clarify that if he used his gait belt to transfer, he would have to had made close contact with her. V17 responded, "But I didn't step on her foot or anything." Surveyor asked if he called for any assistance as R3 required two people to transfer her and she couldn't understand English or Spanish, V17 stated, "No because I was just helping her out and her regular CNA was on her lunch break." Surveyor asked if he called for anyone else to assist with translation or transfer, V17 stated, "No." Surveyor asked if he was in a hurry, V17 stated, "No I took my time." Surveyor asked if R3 asked him for a pillow, V17 stated,

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S9999	Continued From page 9 "Yes and I tell her she already had 3." Surveyor asked why he didn't just give R3 another pillow, V17 stated again, "Because like I say, she already had 3 so I gave her one more after she keep telling me she need one more." On 5/13/21 at 5:45 PM, records show R3 was discharged to home accompanied by daughter after being admitted to facility for rehabilitative therapy on 5/7/21. Interview on 5/13/21 at 1:15 with V1 stated, "I've already counseled V17 on the phone and will do it again in person when he is scheduled back to work tomorrow." Surveyor clarified whether the incident report was final, and he concluded all his findings, V1 stated, "Yes, I will give you the final report." V1 presented final report to surveyor including facility's initial and final incident investigation. Both reports show no interviews with any residents that V17 was assigned to or other potential witnesses that may have observed V17 with other residents. Facility's policy dated November 22, 2017 titled "Abuse Prevention Program" states in part (but not limited to): "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents,	S9999		

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S9999	Continued From page 10 irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by a licensee, employee or agent. Mental abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, agitation or degradation. Neglect is the facility's failure to provide, or willful withholding of personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish of a resident." Internal Reporting: All residents, family members or others are encouraged to report their concerns or suspected incidents of potential abuse, neglect, mistreatment to the administrator or an immediate supervisor who must then immediately report it to the administrator or the designated individual in the administrator's absence. Such reports may be made without fear of retaliation. Reports will be documented, and record kept of the documentation. Protection: The facility will remove any alleged perpetrator(s) of abuse or neglect from any further contact with residents pending an investigation. If the alleged perpetrator is an employee, the employee will be sent home and/or advised not to return to work until further notice. If that employee shall be immediately suspended without pay from employment at the facility, hot having any further resident contact, pending the	S9999		

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S9999	Continued From page 11 outcome of an investigation. Investigation: As soon as possible after an allegation of abuse, neglect, mistreatment, the administrator or designee will initiate an investigation into the allegation which may include the following elements: Interviewing all persons who may have knowledge of the alleged incident, including but not limited to: All persons who reported the suspicion, allegation or incident, the alleged victim, the alleged perpetrator, any witnesses or potential witnesses to the alleged occurrence or incident, any staff having contact with the resident during the period of the alleged incident, roommates, other residents, family or visitors." (B)	S9999		