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	IL6002828	A. BUILDING: ______ B. WING ______	C 09/26/2022

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S 000	Initial Comments Complaint Investigations 2276767/IL150500 2277173/IL150988	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 300.3240b) 300.3240c) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. 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	S9999	Attachment A Statement of Licensure Violations	

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the resident's representative and to the Department.

This REQUIREMENT is not met as evidenced by:

A. Based on interview, and record review, the facility failed to ensure residents were free from mental abuse per facility policy. This failure resulted in R1 and R7 becoming fearful of being involuntarily discharged by V1. This applies to 2 of 5 residents (R1 and R7) reviewed for abuse in a sample of 7.

B. Based on interview, and record review, the facility failed to ensure resident allegations of abuse against V1 (Administrator) were reported to Illinois Department of Public Health and investigated per facility policy. This applies to 2 of 5 residents (R1 and R7) reviewed for abuse in a sample of 7.

The findings include:

1. Face sheet, printed 9/20/22, shows R7 was admitted to the facility on 5/6/22 and had diagnoses including chronic kidney disease, unsteadiness on feet, spinal stenosis, myasthenia gravis, oxygen dependence, and chronic obstructive pulmonary disease. MDS(Minimum Data Set Assessment), dated 7/26/22, shows R7 was cognitively intact. Review of R7's care plan provided 9/21/22 shows no concerns with behavioral outbursts. Progress notes for R7, dated 8/1/22 - 9/13/22 were reviewed and failed to show R7 had any yelling or behavior outbursts documented in the clinical record.

On 9/15/22 at 3:26 PM, R7 stated on 8/26/22 she had radiation for her breast cancer and returned to the facility in a bad mood. R7 stated she never

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S9999	Continued From page 2 yells at staff, but she became aggravated when a CNA (Certified Nurse Assistant) would not provide her ice chips due to her fluid restriction. R7 stated she yelled at the CNA and later apologized to the CNA for yelling. R7 stated the next day, V1 came into her room while she was in her wheelchair and V1 sat on her bed. R7 stated V1 told her, "Unless I change my attitude, I will have to leave." R7 stated V1 then said his main concern was R7 eating ice chips. R7 stated V1 was nasty and threatening in the way he said it. V7 stated "He was calm but like he meant business. But I was scared." R7 stated she became angry, felt very unwanted, felt like V1 wanted to throw her out of the facility, and R7 wanted an apology from V1. R7 stated she felt , "like [V1] wanted to throw me out! Just throw me out!" R7 stated she was unable to fall asleep for a few nights, would toss and turn in bed, and kept thinking about the incident. R7 stated she was concerned that if V1 kicked her out of the facility, she was not sure where she would go. R7 stated she considered which children she could live with but was concerned because her children were very busy. R7 she was also concerned because she sold her condo and felt she had nowhere to go. R7 sated her son called the ombudsman because he was very concerned about her welfare. R7 stated she spoke again with V1 and stated, "I told [V1] you hurt me very bad. I was very upset." On 9/14/22 at 4:28 PM, V6 (Ombudsman) stated on 8/26/22, R7 complained that V1 told her, "Things are going to have to change or you are not appropriate here." V6 stated she told V1 that she had residents approaching V6 about things V1 was saying at the facility and told V1 that what he said made them feel there was a threat they would be discharged. V6 stated V1 apologized to	S9999		

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R7.

On 9/21/22 at 3:26 PM, V1 stated he was the facility abuse coordinator. V1 stated if a resident or staff accused V1 of abuse, the resident/staff would not necessarily have to report the abuse directly to V1. V1 stated the accuser could tell a different staff person who would ultimately tell V1 of the allegation. V1 stated at that point V1 would assign another staff to investigate V1's alleged abuse. V1 stated never told R7 if her behavior did not change, she would have to leave the facility. V1 stated V6 never told V1 that R7 felt she may need to leave the facility if her behavior did not change. V1 stated, "No, that was never conveyed to me." V1 stated V6 stated R7 was upset and hurt by the conversation they had about R7 needing to follow her fluid restriction. V1 stated V6 told V1 "it would go a long way to clear the air with her which was what I did." V1 stated he did not write a grievance regarding R7's/V6's concerns about their conversation.

Review of facility concern logs and abuse investigations, dated 1/1/22 to 8/20/22, fail to show any concerns reported regarding R7.

On 9/21/22 at 6:01 PM, V1 was informed of R7's ongoing concerns about alleged abuse by V1 towered R7. V1 stated, "This information is just not true." V1 stated he was not abusing or threatening any residents and stated an ombudsman was walking around his facility influencing residents . V1 stated he spoke with R7 when her allegations were originally reported to V1 by V6 and V1 stated, "We worked it out ...." V1 stated, "I don't know what you expect me to do! I am the administrator and the owner! ...It's their word against mine. My word has weight in the facility. If you ask my staff and the people

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who have witnessed these interactions, you would find this absurd." V1 failed to state he would investigate the allegations at the facility.

As of 8:00 AM on 9/26/22, no initial abuse investigations were submitted to Illinois Department of Public Health by V1 or any staff at the facility.

Resident rights document provided within the facility admission packet shows facility residents have the right to make their own choices, the facility must treat residents with dignity and respect, residents must not be abused/neglected/exploited, the facility must ensure that residents are free from retaliation, residents may participate in developing a person-centered care plan that states all the services your facility will provide including the facility making reasonable arrangements to meet your needs and choices, and residents have the right to request, refuse and/or discontinue any treatment.

Facility Policy and Procedure Manual Ethics - Abuse Prevention, effective 5/8/22, shows, "The facility shall have zero tolerance for abuse, physical, mental, sexual, or verbal in regard to the care of residents. Abuse means the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ...." The policy states, "The facility shall work to prevent abuse by: ...B. Investigating all reports of abuse immediately C. Reporting all investigations of abuse to the Illinois Department of Public Health immediately and completing investigations within five days. D. Separating all employees accused of abuse from the accuser during investigation and permanently severing employment on all

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sustained findings of abuse. E. Provide adequate staffing and support for direct care staff, which shall include rotation of assignments away from verbally abusive residents .... I. Project residents during investigation .... If an employee is involved, remove from current schedule until the investigation is complete ...." The policy shows, "Identification, Abusive Situations ... B. Events such as: ...2. Fear of certain individuals ... C. Patterns of behavior Employees who are alleged to be abusive towards residents without substantiation shall have each reported allegation kept in their personnel file for comparison. V. Investigation of Abuse A. All incidents and allegations of abuse shall be reported to the Administrator. The policy fails to show any alternative contact to whom abuse should be reported if the abuser is allegedly the Administrator. The policy shows, "E. Conduct of Investigation ... 3. Interview of all parties shall be in private.

2. Face sheet, dated 9/13/22, shows R1 was admitted to the facility on 2/8/22 and R1's diagnoses included inclusion body myositis, depression, adjustment disorder, and adjustment insomnia. MDS, dated 2/16/22, shows R1 was cognitively intact, R1 was totally dependent on staff for bathing, required the extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and R1 required the extensive assistance of one staff for eating. MDS, dated 8/3/22, shows R1 remained cognitively intact and required total assistance from staff for transfers, eating, bed mobility, bathing, and hygiene.

On 9/13/22 at 11:10 AM, R1 stated V1 was very evasive, elusive, and R1 never got straight answers from V1. R1 stated V1 did not like that R1 complained about the quality of nursing care

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at the facility and R1 felt V1's objective was to pronounce R1 mentally incompetent so V1 could control R1. V1 stated "When the manager of the nursing home behaves the way he does, deceives, lies, manipulates- if he can't be ostracized from the profession, he needs to be closely managed and supervised." R1 stated everything V1 has done to R1 was about complete control - including repetitively requesting R1 submit to a psychological evaluation, denying hospice services, and proceeding with an involuntary discharge because R1 complained about the care R1 was receiving at the facility.

On 9/13/22 at 10:11 AM, R1 stated he was being involuntarily discharged from the facility because he was told the facility did not have the ability to assist R1 with his ongoing deteriorating condition. R1 stated if V1 would have been able to document he was failing mentally, the facility would not have to been forced to deal with R1's deteriorating condition as R1 requested. R1 stated he asked V1 if he could hire a private caregiver to help him at the facility which V1 did not allow. R1 stated the involuntary discharge came out of the blue and R1 had concerns regarding retaliation from V1. R1 stated if he brings up an issue of concern, V1 takes a defensive stance. R1 stated there were several excellent caregivers at the facility, but R1 also expressed concerns to V1 about other caregivers who left him in pain and refused to turn him when requested. R1 stated it was his understanding V1's reason for discharging R1 from the facility because R1's body was deteriorating. R1 stated, V1 "basically just wants to get rid of me."

On 9/15/22 at 2:31 PM, V14 (R1's family member) stated on admission, R1 and the family

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wanted to clarify in the admission contract what would cause and involuntary discharge prior to signing the contract - which delayed the signing of the contract. V14 stated that was the first time V1 verbally threatened to involuntarily discharge R1 if V14 did not sign and return the contract to V1. V14 stated she was attempting to clarify terms of the contract for R1 who wanted to be the individual to sign the contract. V14 stated V1 provided the information in writing to clarify what would cause an involuntary discharge. V14 stated nothing in that clarification was similar to why V1 ever stated R1 must be involuntarily discharged. V14 stated R1 was threatened by V1 to be involuntarily discharged three times - once (verbally) when R1 did not sign his admission contract fast enough, second (verbally) when no staff explained to R1 why he needed to use a different mechanical lift instead of his usual mechanical lift and R1 refused, and third (in writing) after V1 blocked R1's preferred hospice from meeting with R1.

Progress note written by V1 on 8/11/22, shows, "Involuntary discharge paperwork filed for resident. Please see form in miscellaneous tab for more information."

Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, dated 8/11/22, shows the facility determined they would transfer or discharge R1 on 9/10/22 due to, "your welfare cannot be met in this facility, as documented in your clinical record by your physician."

On 9/13/22 at 3:03 PM, V1 stated R1's involuntary discharge was initiated after talking to V5 (Primary Physician). V1 stated V5 wrote a note in the clinical record which stated R1's

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needs could not be met at the facility. V1 stated R1 did "not perceive his needs are being met." V1 stated examples of R1's needs which were not perceived to be met included staff not being timely and not adequately giving R1 a bath. V1 stated R1 was upset with the way the facility staff were giving baths even when the facility staff even took time to make sure they adjusted temperatures to R1's preferences. V1 stated he never spoke to R1 about his baths. V1 stated in general R1 was unhappy with the facility CNA response time. V1 stated the facility far exceeded the hours of care required for R1's needs and were adequately staffed to provide for R1's care needs. V1 stated R1 perceives his needs were not being met and R1 was unhappy and was thus being involuntarily discharged from the facility.

On 9/14/22 at 3:29 PM, V5 (Primary Physician) stated he was aware V1 was attempting to involuntarily discharge R1 from the facility. V5 stated he told R1 there was no medical reason R1 had to leave the facility. V5 stated his progress note was in no way intended to justify an involuntary discharge of R1. V5 stated he never said anything about R1 having to leave the facility. V5 stated, "That was not my intent or impetus for writing the note." V5 stated he was told by V1 that the facility was not able to sustain the level of care R1 required and, since R1 had been at the facility, the facility had to allocate more hours to R1 for showers, turning, and pericare. V5 stated V1 told V5 that R1 required three times the nursing care of any resident. V5 stated R1 had essentially required total assistance with care since he was admitted due to his disease. V5 stated he was aware R1 feels that V1 intimidated R1 which is why V5 suggested R1 would be happier at a different facility. V5 stated he did not feel V1 was intimidating R1 and

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felt V1 was doing all he could to help R1. V5 stated he thought the involuntary discharge was essentially about R1's complaints of care - that R1 was complaining he was getting one bath a week and wanted two a week. V5 stated R1 was complaining the call light response time was a problem, especially on second shift, and that staff were in a hurry to do things. V5 stated R1's primary concern with care involved second shift nursing staff.

8/10/22 Physician Visit Note "patient continues to have a gradual decline despite appropriate facility and medical staff interventions. Pt is clearly unhappy with current situation and not amenable to any interventions offered. Patient would likely benefit from transfer to a facility where he perceives his needs are being met. Of note, he has declined all Behavioral Health Services."

Physician Progress Note, dated 8/16/22, shows " ...we discussed care at length. We discussed progressive terminal nature of the disease and his frustrations with his dependence in all ADLs (Activities of Daily Living) .... He is inconsistent at times during the conversation, alternating between the care being 'excellent' and the 'best' he will get anywhere to the care is 'terrible' and 'no one cares for him' at the facility. I reinforced the importance that he is comfortable where he is. I did previously present him with a handful of facilities to look at as alternatives to [facility]. He states his daughter did this, however, they did not work his progressive disease progress, it is important that he in a facility where he is completely comfortable. Will touch base with administration as well as there is an involuntary discharge pending."

On 9/14/22 at 2:58 PM, V6 (Ombudsman) stated

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S9999	Continued From page 10 V1 stated R1's level of care was unsustainable with his condition which was why R1 was being discharged. V6 stated she told V1 that R1 had the condition and care requirements when he was admitted to the facility. V6 then stated V1 stated R1 was being involuntarily discharged because nothing was ever good enough for R1. V6 stated V1 stated he was not discharging R1 to a different facility but to R1's daughter so she can take him home and be in charge of R1. Review of facility concern logs and abuse investigations, dated 1/1/22 to 8/20/22, fail to show any concerns reported regarding R1/R1 Family. Facility Assessment Tool, reviewed 6/15/22, shows the facility's resident disease/condition profile included the following diagnoses: Parkinson's disease, hemiparesis, hemiplegia, paraplegia, quadriplegia, multiple sclerosis, dementia, stroke, traumatic brain injuries, Huntington's disease, and cerebral palsy. The assessment shows, "Clinical needs, staff availability, staff training, equipment availability, medication availability, and resident interactions are all considered prior to admission. For those residents that are current residents and develop a new diagnosis that isn't listed above, the same process is followed to identify if the facility can meet the needs of the resident. If the facility is unable to care for a resident safely, the resident is not admitted, or transferred to a setting that is more appropriate." The assessment shows the facility cares for residents dependent on dressing, bathing, transfers, eating, toileting, and mobility. The facility services and care offered by the facility based on resident needs include bathing, showers, oral/denture care, dressing, eating, support with needs related to	S9999		

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S9999	Continued From page 11 hearing/vision/sensory impairment. The facility also offers assistance/services of transfers, ambulation, restorative nursing, contracture prevention/care, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. The assessment shows the facility provides pain management, ostomy care, tracheostomy care, ventilator care, bariatric care, and end of life care. The facility assessment shows, "Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff are caring for the resident have this information. Record and discuss treatment and care preferences. Hospice contract, signed by V1 (Administrator) and V20 (Hospice Administrator), shows the facility and R1's preferred hospice service had a contract signed and effective on 4/18/2021. The contract term was for one initial year which was then automatically renewed for a successive one year unless one party provided thirty days' notice of termination, or unless immediate termination/termination for cause occurred per contract definitions. On 9/15/22 at 10:25 AM, V21 (Hospice Administrator) stated to date the hospice service had not received, or provided, any notification of cancellation of the contract between the hospice and the facility. V21 stated the contract is automatically renewable every year unless a 30-day notice is provided by either party. On 9/13/22 at 11:00 PM, V1 stated he never had a contract with R1's preferred hospice at the facility. Physician note, dated 6/14/22, shows "	S9999		

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S9999	Continued From page 12 ...Discussed concerns regarding care. Numerous concerns regarding nursing, we discussed at length. He did not feel hospice was what he wanted nor was palliative care which I felt would be much more appropriate." Physician progress notes, dated 7/27/22, also show V5 (Primary Physician) discussed the option of hospice services for R1 which were declined at the time. VA Hospice Referral, dated 8/15/22, shows R1 was ordered hospice evaluation and treatment on 8/15/22 at 11:31 AM. On 9/12/22 at 1:27 PM, V14 stated she approached V1 regarding utilizing their preferred hospice service and V1 told V14 that R1 was not a candidate for hospice, that V1 was going to block R1's admission to hospice, and that V5 (Primary Physician) would agree with V1. V14 stated the facility initially refused to release R1's medical information to the hospice per R1's request. V14 stated R1 had to personally demand his medical records so V14 could provide them to the hospice and eventually the facility provided the records. V14 stated V1 told V14, "You don't know about this industry. This is my facility and my call, and your dad is not a candidate." V14 stated she approached the Veteran's Administration (VA) as well as the VA-associated hospice and scheduled an evaluation on 8/15/22 by the VA-associated hospice which R1 and V14 preferred to use. V14 stated the facility was aware their preferred hospice was coming to see R1 however when the hospice was visiting with R1, V1 came to the room and stated he did not give permission for R1's preferred hospice to visit R1. V14 stated V1 told the hospice representative, "Who are you and what are you doing in my building? I did not give you permission to be here. It's my facility and I can tell you who comes and who goes, and	S9999		

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you need to leave." V14 stated she told V1 the hospice and the facility already had an established relationship and contract, but V1 refused to let the hospice visit with R1. V14 stated R1 feels it is wrong and wants to pursue this hospice because he knows that the facility denying him access to his preferred hospice is wrong. V14 stated R1 is terrified regarding retaliation. V14 stated he did have good, established relationships with some direct care facility staff and R1's wife was there at the facility with dementia, and R1 did not want to start over in a different facility. V14 stated, "If you heard some of the bullying that comes out of his mouth to dad and me, you wouldn't believe he was in this industry."

On 9/15/22 at 2:31 PM, V14 stated the facility was aware R1 had approval from a VA physician to begin hospice with R1's preferred hospice at the time the hospice visited the facility. V14 stated as of 9/15/22, R1 was still "in a holding pattern with hospice." V14 stated V1 claimed the hospice was not certified to work at the facility and V1 claims he does not know that hospice service. V14 stated V1 previously insisted on a meeting with their preferred hospice which was scheduled at the facility. V14 stated the hospice attended the meeting at the facility to reintroduce themselves to their business partners, but V1 would not attend the scheduled meeting.

Email correspondence, dated 9/8/22, shows V18 (Preferred Hospice Representative) stated she met with V19 (Admissions) and V4 (Office Staff) at the facility on 6/15/22, but V1 was too busy to join the meeting. The email shows during the meeting V18 asked V19 why R1's medical records were not being provided to the hospice and V18 was told by the facility R1's records were

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not provided was because V1 and V5 "...did not feel that [R1] was appropriate and that is why they could not share his medical records or want a hospice evaluation done. [V18] asked what the protocol was for moving forward and [V19] stated that V1 and V5 had to approve it ...." The email shows V14 was the individual who provided the hospice R1's medical records. V18 stated on 8/15/22 R1/R1's family and their preferred hospice met in R1's room for V18 to provide hospice program information as the hospice was waiting for a physician order from the VA for hospice services (which they received while the representative was there). The email shows V18 and V19 discussed the full contract between hospice and the facility which was signed 4/2021. The email shows V4 (Office Staff) confirmed she did receive a copy of the existing contract when the hospice initially requested medical records for R1.

On 9/13/22 at 10:11 AM, R1 stated recently a hospice chosen by R1 and his daughter, who at the time had an active contract with the facility, visited R1 to discuss hospice services. R1 stated his daughter and the hospice met with R1 in his room when V1 appeared in R1's room and denied the preferred hospice from any further contact with R1. R1 stated V1 told R1 that R1 did not have the right to approve or coordinate with a specific hospice for R1's care. R1 stated V1 told the hospice representative, "'I tell you when and if you can come, you don't come on your own!' and that is when the sparks start flying." R1 stated V1 told the individuals present only V1 could approve a hospice. R1 stated the conversation became difficult and V1 threatened to call the police who eventually arrived, and the hospice left. R1 stated V1 came to his room recently and stated he was offering R1 three different hospices from

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S9999	Continued From page 15 which to choose. R1 stated he told V1 he did not want to discuss hospice with V1 any further. R1 stated he would never talk to V1 regarding a psychiatric evaluation or hospice again. On 9/13/22 at 3:03 PM, V1 stated at one-point R1 and his family asked for hospice to be initiated. V1 stated after speaking with V5 (Primary Physician), it was determined hospice was not appropriate for R1 at that time. V1 stated approximately a month later, V1 and V5 determined R1 would be appropriate for hospice and V5 wrote an order for a hospice evaluation. V1 stated he spoke with R1 regarding options of hospice companies that visited the facility, however V1 could not recall if that conversation happened on 9/2/22 as documented in the clinical record. V1 stated when he confronted the family-chosen hospice company in R1's room, V1 stated R1 did not have physician orders for a hospice evaluation. V1 stated the facility needed physician orders prior to performing a hospice evaluation and the hospice performing the evaluation also required a contract for the facility. V1 stated he did not tell the hospice to leave R1's room, but that they left on their own. V1 stated residents were uncomfortable and V1 felt threatened by V14 which was why he called the police. V1 stated after he got physician orders, he brought R1 a list of facility-approved hospices from which to choose. V1 stated he documented that visit in the clinical record. V1 stated he did not care which hospice R1 chose, but that the facility has policies/procedures as to how to include a hospice within the facility. V1 stated the facility must have a contract for the facility to accept a hospice involvement for a resident. V1 stated he did not care which hospice a family used but they must follow policies/procedures of the facility when utilizing hospice.	S9999		

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S9999	Continued From page 16 Progress note written by V1 on 9/2/22 shows, "This writer spoke with resident regarding the physician's order for a hospice evaluation. Gave resident three options as far as hospice provider and asked resident if he would like me to coordinate the evaluation. He said no thank you, not at this time. He stated he would let me know if he changes his mind." Email correspondence between V1 and V6 (Ombudsman), dated 9/2/22, shows V1 communicated to V6 that he provided R1 with three choices of hospice, none of which were R1's preferred choice for hospice. The email shows V1 stated he did not have a contract with R1's preferred hospice. On 9/14/22 at 3:29 PM, V5 (Primary Physician) stated V1 told V5 that V1 removed R1's choice of hospice out of the facility because the hospice was not contracted at the facility. V5 stated V1 told V5 he was attempting to get the hospice of R1's choice contracted so that R1 could utilize the hospice of his choice. V5 stated he and V1 had several conversations about working with the hospice of R1's choice so that R1 could utilize the hospice service. Email correspondence, dated 9/15/22, shows V21 (Hospice Administrator) wrote on 8/15/22, the hospice nurse arrived at the facility to meet R1 and R1's family to discuss hospice after receiving a verbal order from R1's Primary Care Physician and after speaking to the VA to obtain authorization. The email shows during the informational meeting between R1's preferred hospice and R1/R1's family, the hospice representative was told by a member of the facility leadership that she would have to	S9999		

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discontinue the appointment, or he was going to call the police. The email shows the representative concluded the appointment.

Physician note, dated 8/23/22 shows, "FTT (Failure to Thrive) - slow decline with accelerated weight loss - ok to proceed with hospice per family wishes .... "

POS, printed 9/14/22, shows a physician order (dated 8/30/22) for R1 to receive a hospice evaluation.

On 9/14/22 at 2:58 PM, V6 (Ombudsman) stated she spoke with V1 a few weeks prior and told V1 that R1 wanted to utilize the hospice of his choice which was the hospice that was removed from the facility the day the police were called to R1's room. V1 told V6 the hospice was not contracted with the facility and V6 asked if they could be approved. V6 stated V1 told her that he could agree to a contract, but he would not. V1 could not trust them because they came into the facility without V1's permission. V1 told V6 that he would ask V5 for an order for R1 to have hospice. V6 stated in an email, V1 stated he would talk to V5 about obtaining a hospice order for R1, but V1 would only offer three hospice agencies which did not include R1's choice for hospice. V6 stated she asked why he would not offer R1's choice for hospice and V1 replied the reason was because he did not have a contract. V6 stated V1 never answered her question about pursuing a contract so R1 to use the hospice of his choice.

Facility policy/procedure Hospice Policy, dated 1/5/18, shows "Elmhurst will coordinate hospice services with resident's hospice of choice that is contracted with the facility for resident's overall quality of care .... Resident and resident

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representative has the preference to choose the Hospice of their choice and the facility will contract with that particular Hospice company."

On 9/21/22 at 6:01 PM, V1 was informed of R1's ongoing concerns about alleged abuse by V1 toward R1 including concerns of retaliation and intimidation because of R1's reports of care concerns to R1. V1 failed to state he would investigate the allegations at the facility.

As of 8:00 AM on 9/26/22, no initial abuse investigations were submitted to Illinois Department of Public Health by V1 or any staff at the facility.

4. On 9/13/22 at 10:11 AM, R1 stated he reported a CNA to the facility and V1 who refused to turn R1 in bed several times when he was in pain. R1 stated he asked the CNA to turn him to relieve his pain and the CNA refused to do so and walked out of the room. R1 stated V1 later walked into R1's room with V3(CNA) and confronted R1 about his allegation with V3 present. R1 stated V1's approach was extremely unprofessional and felt V1 wanted to believe V3's story and prove R1 was wrong. R1 stated V1 was "unprofessional, cold, callous, and inconsiderate." R1 stated there were many very good caregivers at the facility, but when he reported concerns to V1, V1 became defensive and difficult toward R1.

On 9/14/22 at 9:11 AM, V10 (Former MDS Coordinator) stated R1 was very intelligent, alert and oriented but could not physically control his body due to his condition. V10 stated she was interviewing R1 for an assessment and R1 reported to V10 that V3 (CNA) "was mean to him

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overnight." V10 stated she reported the allegation to V1 verbally. V10 stated she followed up with R1 a week later regarding his concerns. V10 stated R1 was very upset because V1 brought V3 into R1's room to confront R1 about his allegation in front of V3. V10 stated V3 continued to work with R1 after the confrontation as well.

On 9/13/22 at 3:03 PM, V1 stated he did not recall R1 ever complaining about care from V3 (CNA) and did not recall any complaint regarding V3. V1 denied bringing V3 into R1's room to confront R1 about his concerns with V3's lack of assistance. V1 stated, "That would be unprofessional ...."

Review of facility grievance logs and abuse investigations dated 1/1/22 - 9/20/22, show no concerns identified at the facility by R1.

Email correspondence with V1, dated 9/20/22, shows V1 confirmed there were no facility grievances or abuse investigations regarding R1 from 1/1/22 - 9/20/22.

On 9/21/22 at 6:01 PM, V1 was informed of R1's ongoing concerns regarding allegations of abuse by V3 toward R1. V1 failed to state he would investigate the allegations at the facility. As of 8:00 AM on 9/26/22, no initial abuse investigations were submitted to Illinois Department of Public Health by V1 or any staff at the facility.

5. POS (Physician Order Sheet), printed 9/14/22, shows R1 had a physician order (dated 3/13/22) for, "Psychology and psychiatry evaluation and

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treatment consented by daughter" as ordered by V5 (Primary Physician). The POS also shows a physician order (dated 3/13/22), for "psychology and psychiatry evaluation."

Physician note, dated 8/23/22, shows, "Continue to offer BH (Behavioral Health) services, patient has so far declined."

Initial psychiatric assessment, dated 4/6/22, shows "[R1] is referred by [his] primary care physician (PCP) for isolated behavior given his terminal illness. No prior psych history and not on any psychotropics. Pt (patient) met in room, pt had several questions about this visit and was agreeable to talk about his condition. Patient states he has a terminal illness and lost some weight due to muscle wasting, no strength on his legs and in a lot of pain, hardly sleep at night states he is adjusting with is problem and denies any need of medications .... Pt was recommended to start on Remeron initially, per facility request changed to Lexapro given patent's terminal illness and adjustment difficulty. However, family was agreeable, but patient refused to be on antidepressant. Patient doesn't think he need to be on any medication even if he has sleeping difficulty."

Psychiatric Subsequent Assessment, dated 5/6/22, shows R1 was seen for symptoms of depression by V15 (Psychiatric Nurse Practitioner).

On 9/13/22 at 10:11 AM, R1 stated within three weeks of his stay at the facility, V1 wanted to have a psychological evaluation performed on R1. R1 stated V1 began with welcoming conversations but R1 stated he later felt V1 wanted to test R1 to see how mentally impaired

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R1 was. R1 stated when V1 asked if R1 would submit to a psychological evaluation, R1 stated he felt like he misunderstood V1 and asked, "Don't you mean a physical evaluation?" R1 stated V1 never gave a straight answer. R1 stated V1 approached R1 several times requesting R1's permission for a psychiatric/psychological evaluation and R1 stated he never gave consent for a psychiatric/psychological examination. R1 stated his relationship with V1 "went downhill after that." R1 stated V1 was antagonistic, argumentative, and demanding. R1 stated there were dozens of incidents and conflict with V1 since his admission. R1 stated, "I don't care about personal conflict, but I do care about getting help for my physical condition. Hate me [V1] ... but help me! No help. Nothing."

On 9/15/22 at 2:31 PM, when asked if R1 wished to have a psychiatric/psychological evaluation, V14 (Family) stated, "My dad would never, ever, ever do it! Absolutely not! My dad doesn't need it! Even in the beginning! My dad was suspect of [V1] even from the beginning!" V14 stated the facility called her and requested permission to give R1 a psychological/psychiatric evaluation and V14 stated she never gave permission. V14 stated R1 was completely able to make his own decisions. V14 stated V1 confronted R1 early on after admission to the facility (possibly March or April) and told R1 he had to have a psych evaluation but R1 refused to be evaluated. V14 stated V1 approached R1 a few times about having the evaluation and R1 was suspect. V14 stated he asked a nurse about the evaluation and the nurse told R1 not to agree to it because V1 would have more control over R1's care.

On 9/14/22 at 8:45 AM, V9 (DON- Director of

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S9999	Continued From page 22 Nursing) stated V1 was pushing R1 to have a psychiatric evaluation and R1 continued to refuse to have the evaluation. V9 stated she told V1 it was R1's right not to have a psychiatric evaluation because he was completely alert and oriented, very intelligent, and his brain was working perfectly. V9 stated even after being told R1 refused, V1 continued to push V9 to tell R1 he needed a psychological evaluation. V9 stated she had a closed-door meeting with R1 to remind him that he had the right to refuse the psychological/psychiatric evaluation and encouraged him to involve his family including his brother who was a physician. V9 stated she knew R1 did not want the evaluation but when V1 kept pushing R1 to accept the evaluation, V9 announced R1 was refusing the evaluation in front of co-workers and V1 at a morning meeting. V9 stated the meeting included V1's mother who works in accounting, V9's girlfriend who is the dietitian, and several co-workers that no longer work for V1. V9 stated after she publicly stated R1 was refusing the evaluation, V1 approached R1 again in R1's room and asked him several times to submit to an evaluation. V9 stated V1 was a very demanding manager and insisted on having his way which was why her employment did not work out with V1. V9 stated V1 wanted people do what he said, or he would get very upset and intimidating. V9 stated V1 would get very upset, including fire employees, if people did not follow his direction even when V1 was told what he was doing was not right. V9 stated, "If I have to go to court I will speak up. This guy has no right to take care of these residents." V9 stated R1 was requesting reasonable accommodations for his care, but V9 stated V1 felt R1 was being difficult so V1 was pushing for a psychological evaluation. V9 stated R1 just wanted good care. V9 stated V1 also pushed	S9999		

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hospice choices on residents in situations.

On 9/14/22 at 9:11 AM, V10 (Former MDS-Minimum Data Set Coordinator) stated, "I thought it was nuts when I heard it!" regarding V1 wanting R1 to have a psychological/psychiatric evaluation. V10 stated R1 became very upset about a personal care issue and after that V1 began wanting to perform a psych evaluation on R1. V10 stated she was in the morning meeting when V9 made it clear R1 was refusing the evaluation and V1 became very angry. V10 stated she explained in the meeting that R1 was upset when he was turned because he was in pain which was completely understandable in his condition. V10 stated she felt V1 was not pursuing R1's evaluation because R1 had cognitive concerns, but because V1 was upset with R1 and wanted to control people.

On 9/14/22 at 3:29 PM, V5 (Primary Physician) stated R1 was alert and oriented and V5 never wrote R1 an order for a psychiatric evaluation. V5 stated R1 always refused V5's suggestions to be evaluated and has no recollection of placing a psychiatric consult order in R1's chart. V5 stated he felt R1 would benefit from counseling, but R1 always declined the offer for the facility to provide counseling. V5 stated R1 was intellectually a very high cognitive functioning man dealing with a debilitative disease and would become frustrated easily. V5 stated R1's biggest complaints were care at the facility which were always indicative of staffing.

On 9/14/22 at 9:39 AM, V7 (Advanced Practice Nurse) stated she never thought R1 needed a psychiatric evaluation because he was very alert, oriented, and intelligent. V7 stated she thought because of R1's debilitative condition R1 could

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMHURST EXTENDED CARE CENTER	200 EAST LAKE STREET ELMHURST, IL 60126

(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
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benefit from psychological counseling. V7 stated she asked R1 if he wanted to talk to someone regarding counseling and R1 declined saying he had family support. V7 stated she never thought R1 was not able to make decisions. V7 stated when she spoke with R1, R1 had small complaints regarding the facility, but no major complaints. V7 stated R1 "just wanted good care which he was entitled to. He loves the CNAs (Certified Nursing Assistants) and is very happy with his bathing." V7 stated she felt the culture at the facility was "whatever V1 says it goes." V7 stated there were conflicts between V1 and other staff at the facility and then those staff were then no longer working at the facility.

On 9/20/22 at 12:35 PM, V15 (Psychiatric Nurse Practitioner) stated she was not aware that R1 had refused suggestions to be evaluated by psychiatry/psychology when she evaluated R1. V15 stated she received a referral to see R1 and usually the facility asks permission from the resident or power of attorney before she is sent to see a resident. V15 stated R1 asked questions during the initial evaluation such as who told V15 to see R1 and what was the reason V15 was there. V15 stated R1 stated he did not need V15's services. V15 stated R1 was completely alert and oriented and could make his own decisions. V15 stated she was not aware R1 had consistently declined to have a psychiatric/psychological evaluation.

"B"