

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014633</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/24/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INVERNESS HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1800 COLONIAL PARKWAY INVERNESS, IL 60067</b>
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S 000	Initial Comments  Facility Reported Incident of January 27, 2022/IL143522	S 000		
S9999	Final Observations  Statement of Licensure Violations: 300.610 a) 300.3240 a) 300.3240 b)  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.  This REQUIREMENT is not met as evidenced by:	S9999	<b>Attachment A Statement of Licensure Violations</b>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from abuse. A staff member (V7) intimidated a resident and created a hostile environment. The facility also failed to have a staff member (V8) recognize a resident was being abused and failed to intervene immediately to stop the abuse and protect the resident. This applies to 1 of 4 residents (R1) reviewed for abuse.</p> <p>As a result, R1 was subjected to the abusive behavior of V7 (certified nurse aide) who mentally abused R1 by making R1 afraid. The facility's investigation did not include all employees' accounts of the abuse incident leaving V7 on duty to intimidate residents.</p> <p>Findings include:</p> <p>The state agency received an abuse incident report from the facility on 1/27/2022. The information included the following: "Patient (R1) is a 95-year-old, short term resident of this facility who is alert, oriented x 3. (R1) has DX of Femur Fracture, Spinal Stenosis, polyneuropathy, Polyarthrits, Anxiety, hypertension. On 01/27/22, resident reported to DNS (Nurse) that CNA from last night was very mean to (R1), refused to help (R1) and hit (R1) on the face while telling (R1) to go to the bathroom even after (R1) told her (R1) didn't have to go. Upon learning about the allegation, the facility initiated an investigation. CNA was placed on suspension pending result of investigation."</p> <p>"Immediate corrective / protection actions documented in the report: MD (Medical Doctor) and POA (Power of Attorney) notified 2) Full body assessment done on resident 3) CNA was placed</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>on suspension pending result of investigation. 4) Staff and resident interviews initiated 5) Body checks on all residents in the unit with BIMS&gt;10 6) n abundance of caution, Abuse in service initiated."</p> <p>In conclusion the facility reported R1 on 1/31/22 reported "during the provision of care, specifically, helping the resident in the bathroom with toileting, the CNA bumped (R1's) face with her elbow. The resident reports that (R1) did not think this was intentional. The accused CNA (V7) was interviewed. She denied ever elbowing the resident and reported that she did not recall her elbow touching the resident ' s face. After a complete and thorough investigation, the facility could not find evidence to support abuse."</p> <p>According to R1 ' s MDS (minimum data set) assessment dated 1/24/22, R1 had a BIMS (brief interview for mental status) score of 14 showing R1 to be cognitively intact with no confusion and no behaviors indicating any resistance to care. R1's functional ability showed R1 to require maximum assistance in all R1's activities of daily living due to a history of a femur fracture and spinal stenosis.</p> <p>The following interviews were conducted during the investigation:</p> <p>1. On 2/7/22 at 11:00 AM R1 stated, "I'm not feeling too well today." The surveyor asked about what happened on 1/26/2022 (3-11 shift) to R1 with one of the aides who took care of R1. R1 reported, "That CNA (certified nurse aide) was shouting at me and told me to take off my gown off and she made me get in the chair and took me and put me on the toilet, then left me there for</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>over an hour. I told her I didn't need to go to the bathroom, and she was angry with me and kept shouting at me to take my gown off and then she ripped it off of me, and in the process, elbowed my face. She didn't even say she was sorry. She threw my gown in the toilet and I asked her why she did that and she said because it had "sh***" on it so I took it out of the toilet because it was my own personal gown that I liked, and I put it on the floor because it was soaking wet. I don't know why this girl hated me so much, but she frightened me at the time. Everything went so fast, and I was a little shocked this was happening. She was in such a rush to get me on the toilet even though I kept telling her I didn't need to go, and so I shouted out to the hall to get someone's attention, but she even told me to quiet down. I told her (V7) I was going to report her to the nurse, and she said to me go ahead and wouldn't go anywhere because she would tell the nurse first. That's when I saw the nurse (V8-registered nurse/RN) finally come in, but she didn't do nothing either when I tried to tell her what happened. She asked CNA to come outside the room and then the CNA came back and then put me back in the bed and actually said to me "see nothing's going to happen to me." I didn't see the nurse (V8) again until she gave me medications, but the CNA (V7) came back again in my room later on and I pretended to be asleep. The next day (1/27/2022) I complained to another nurse (V9) on what happened to me and then some other nurse (V2-Director of Nursing) and some boss man came and asked how I was doing. The gal (V2) kept trying to justify that the CNA didn't mean to hit my face. How did she know this? V2 kept trying to convince me it was not intentional. So, I just told her (V2) okay so I guess it wasn't intentional, but I also told her that CNA shouldn't be working here if she is that</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>angry. I'm a tough cookie but she should not have treated me like that." Surveyor asked if the CNA (V7) ever took care of (R1) again after that. R1 stated, "No, but next time I will call the police."</p> <p>2. On 2/11/22 at 12:09 PM, interview with V2 (Director of Nursing) stated, "I am the abuse prohibition designee, not the administrator. That's just how it's been with our company that I am the abuse person in charge of investigating abuse, but the administrator (V1) helps too. I conducted the investigation when V9 (RN) reported to me on 1/27/2022, R1 reported to her (R1) was hit in the face by the CNA (V7) on the previous night (3-11 PM). I called V7 at home and interviewed her and told her she was suspended pending the results of the investigation. V7 told me that the resident wanted to be changed while she was passing dinner trays, so she went and assisted the resident to the restroom. V7 said R1's night gown was soiled and R1 didn't want to be changed, but V7 insisted on changing (R1) and told (R1) there was BM (bowel movement) on (R1's) gown. V7 also said that the nurse (V8) was present during all of this. Surveyor asked if R1 was considered a confused resident. V2 stated, "No (R1) is very alert and oriented x 3." Surveyor asked if she interviewed the other nurse on duty as a potential witness to the incident. V2 stated, "No I didn't do that, but I guess I should have." Surveyor asked what the conclusion was to her investigation. V2 stated, "We don't know what actually happened whether the CNA hit (R1) or not because she denied this. When the administrator talked to R1, (R1) said it wasn't intentional but V7 should have asked for assistance to help her if R1 was telling her (R1) didn't need to go to the bathroom because that is (R1's) right. We concluded this was just a customer service issue and we brought V7 back to work after the final</p>	S9999		
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S9999	<p>Continued From page 5 investigation."</p> <p>3. On 2/11/22 at 2:00 PM, V1 (Administrator) presented surveyor with type-written statement by V7 which read: "Attention (V2-Director of Nursing), On January 27, 2021, (R1) had put on (R1) call button because (R1) wanted me to change (R1's) disposable brief because it became soiled. I canceled the light and informed (R1) that I couldn't help because I was passing dinner trays and when I'm done, I could assist. The nurse (V8) was aware of the situation the whole time because she was standing there outside the patient room due to her medication passing for patients on her assignment. The roommate of (R1) had come out the room and walking with her wheelchair screaming that she had a cup of tea had soiled her bed and she needed help. I told her the same thing that I will help after dinner was over. Don't really know what time it was and didn't think it was a big issue. I came and assisted to transfer (R1) to (R1's) wheelchair to restroom to toilet (R1) and (V8) put her in bed. (R1) was still angry from earlier because I didn't stop what I was doing to help (R1) put on dry underwear. I then stepped out to show privacy and I came back in to provide perineal care and (R1) had soiled (R1's) own personal night gown with feces. I insisted that it had to be removed and (R1) should change it right away and (R1) refused, and I asked (V8) to come in and help and the nurse did. (R1) helped us remove the pajama top and (R1) threw the top in my face and I threw the top on the toilet seat because of the item being with fecal matter on it. I immediately left the room and (V8) tucked in the patient and I left the room. At 8:52 PM, the nurse asked me to change (R1) but at the time I was charting on the people I care for that shift and 20 minutes later I provided clean sheets and the</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>roommate stated be careful going home tonight. I never said anything to (R1) while in the room the whole time. Thanks, (V7)." The typewritten report was unsigned and not dated as to when the report was written by V7.</p> <p>On 2/11/22 at 2:10 PM V1 (Administrator) brought in V7 to speak with surveyor and stated, "I think you were looking for her. She's been working today all along." The surveyor interviewed V7. V7 stated, "That particular day we kind of needed help and we were short-staffed. (R1) said (R1) needed help to be changed so I didn't neglect (R1). I was passing trays and they don't have hot plates to keep the trays warm, so I had to do too many things at once. They wanted me to pass trays and change R1's diapers and take care of my other residents, and so I went right away to change (R1's) diapers first. (R1) became very agitated and became mad at me for some reason. After the nurse passed the medications, it seemed (R1) calmed down, so it was probably (R1's) medications (R1) just needed". Surveyor asked whether she knew the medications R1 took. V7 stated, "No I just know (R1) calms down once (R1) gets them". V7 continued, "So I dropped the dinner trays off to both R1 and R1's roommate. The roommate was screaming about something, but she didn't want my help when I asked her, so I left. After I picked up the trays after they were done eating, I gently took R1 to the bathroom because (R1) had stool in the back of (R1's) gown. (R1) didn't want me to take the gown off, so (R1) took the gown off (R1's) self and threw the gown with poop on it at me." Surveyor asked if the "poop" R1 threw at her hit her. V7 stated, "No. I took it and placed it on the floor." Surveyor asked to clarify who took R1's gown off, " V7 stated, "R1 took off (R1's) gown</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>(R1's) self and then (R1) threw it at me. V8 (RN) was right there when R1 did this so she can tell you exactly what happened". Surveyor asked why R1 would have thrown a night gown at her. V7 stated, "I don't know. Like I said (R1) was already angry at me because (R1) wanted to be changed right away. After (R1) threw the gown at me, I just left the room and told the nurse that I refused to help (R1) anymore so V8 ended up putting (R1) back in the bed because R1 was out of control. I got a call the next day from the Director of Nursing (V2) and she said I had to be suspended because R1 said I elbowed (R1's) face, and I was yelling at (R1)." Surveyor asked if this was true. V7 stated, "No I never touched (R1). (R1) threw a gown at me and I left the room." Surveyor asked if she never touched the resident how R1 got on to the toilet. V7 stated, "Yes, so I put (R1) there because (R1) had "poop" on (R1's) gown." Surveyor asked whether she assisted R1 in removing R1's gown. V7 stated, "No (R1) took it off (R1's) self and then (R1) threw it at me with the "poop" on it because like I said (R1) was angry with me." Surveyor asked if she knew why R1 was angry with her. V7 stated, "Because like I said (R1) needed (R1's) medications and once (R1) got them, (R1) was calm."</p> <p>4. On 2/11/22 at 2:40 PM interview with V8 (RN) stated, "I was the nurse that night when this (incident) happened. It was a very busy night. I was passing medications and I heard arguing and yelling going on with the CNA and the resident, so I approached the room." Surveyor asked if she was able to hear anything that was loudly spoken. V8 stated, "No at first I thought it was the two residents shouting at each other but when I entered the room it was V7 and the resident. I</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>saw (V7) with R1 in the bathroom. I saw the resident's clothes thrown on the ground and V7 shouldn't have been yelling at the resident and I remember telling that to V7 when she left the room. I didn't want to say that to V7 in front of the resident, so I told her outside the room and told her "No more fighting". Surveyor asked whether staff should be fighting with residents as she mentioned. V8 (RN) stated, "No they shouldn't be, but I didn't want to get in their personal business." Surveyor asked whether it was her responsibility to report this immediately to administration. V8 (RN) stated, "I didn't want to get involved." Surveyor asked again whether what she heard and observed between a CNA and a resident warranted reporting immediately to her supervisors. V8 stated, "I've been working in the hospital many years and we run in to this many times, and if I report everything to my supervisor, nobody would be working anymore." Surveyor asked if the hospital setting was the same as a nursing home setting. V8 stated, "I guess you are right, the residents lives here." Surveyor asked if she assisted the CNA in removing R1's night gown as V7 (CNA) explained. V8 stated, "No I wasn't there to do that because (R1's) gown was already on the floor." Surveyor clarified and asked whether at any time she assisted R1 to the bathroom and help R1 remove R1's gown. V8 stated, "No not at all." Surveyor asked if she assisted R1 back to bed as V7 (CNA) mentioned. V8 stated, "No I already left the room, it must have been V7 (CNA) who put (R1) back to bed."</p> <p>Facility abuse prohibition policy revised 3/27/2021 contains the following: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>deprivation goby an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Training: Training of employees will be through the following: Orientation program; ongoing in-service training, annually and more often if needed, one to one counseling when identified, indicators to identify staff burnout. Training will focus on the following topics: Recognizing abuse, neglect, and misappropriation of resident property. Steps on how to report including to whom and when. How to protect residents, staff, and others from immediate danger. Signs of and intervention techniques to be used with residents having aggressive behavior or catastrophic reaction. How to recognize the signs of burnout, frustration, and stress in self and co-workers. Employees' responsibility upon witnessing abuse, neglect or misappropriation of property. Federal standards on resident protection, reporting and investigation</p> <p>Prevention: Staff, residents, and resident representatives will be instructed of how to</p>	S9999		
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S9999	Continued From page 10  identify and report concerns, events, and grievances. They will also be given the name of the facility's designated abuse contact person as well as numbers for state agencies. This will be done through: Resident council, family council, in-service training, 1:1 if indicated.  "B"	S9999		
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