STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002539	A. BUILDING: _____ B. WING _____	C 08/25/2023

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S 000	Initial Comments Complaint Investigation 2356884/IL163375	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3240 a) 300.3240 b) 300.3240 c) 300.3240 d) 300.3240 g) 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. (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 Department and to the facility administrator. (Section 3-610(a) of the Act) 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 the resident's representative and to the Department. (Section 3-610(a) of the Act) d) 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. (Section 3-611 of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure residents are free from staff to resident abuse; failed to report an allegation of staff to resident physical and emotional abuse to IDPH (the Illinois Department of Public Health)	S9999		

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and local law enforcement; and failed to immediately initiate and thoroughly investigate allegation of staff to resident abuse for one resident of four residents (R3) reviewed for abuse in the sample of 4. This failure resulted in R3, during care on 7/6/23, experiencing physical pain and emotional distress with continued feelings of intimidation, fear, sadness, anxiety and helplessness.

Findings include:

R3's Face Sheet documented an admission date of 3/7/23, and diagnoses including Quadriplegia, Tracheostomy, Pressure Ulcer of the Sacrum, Diabetes Type 2, Morbid Obesity, Hypertension, Anxiety Disorder, Insomnia, Unspecified Depressive Episodes, and Polyneuropathy.

R3's Minimum Data Set, dated 6/12/23, documented R3 has no deficits in cognition, is totally dependent on at least two staff for transfers, bed mobility, dressing, eating, and toileting.

Nurses Note, dated 7/6/23 at 11:54am, authored by V4, Registered Nurse, documented, "Resident accused CNA (Certified Nursing Assistant) of being rough while completing care. Is cursing and yelling at staff. Attempted to console and allowed resident to vent. Administrator and Director of Nurses notified." There was no documentation in the record to indicate R3 was assessed for injuries by nursing staff, or that R3's Physician had been contacted.

On 8/23/23 at 12:05pm, R3 was alert and oriented to person, place, and time. R3 denied she has ever been physically or verbally abused at the facility, stating, "I'm not going to let anybody

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abuse me," and stated, "Some of the staff are always rude, like they're having a bad day." R3 stated staff have not said anything racist to her, but she has heard from staff that V6 has made racist comments to them. R3 stated she does not like V6 because, "She's (V6) probably bipolar." R3 stated she does not think V6 likes R3. R3 stated there was an incident in July 2023 where V6, "Rolled me (R3) over and she wasn't very gentle about it and hurt me, but I can't say it was intentional." R3 stated V6 does not take care of her anymore, since July 2023. R3 stated she did not ask to not have care from V6, and thinks maybe V6 does not want to take care of her anymore.

On 8/24/23 at 10:15am, R3 was tearful, and stated she had been reluctant to speak to the Surveyor on 8/23/23. R3 stated on 7/6/23, V5 and V6 were providing incontinence care prior to showering. R3 stated upon entering the room, V6 seemed to be short with her. R3 stated as V6 was rolling her to her side, R3's flaccid left arm was caught under her body, and due to Neuropathy, she was in extreme pain. R3 stated she yelled for V6 to stop because she was hurting R3, but V6 did not stop. R3 stated she was hollering and V6 was hollering right back at her. R3 stated when the mechanical lift sling was placed under her, V6 stormed out of the room and into the hall, yelling, "I can't do this anymore," and making statements about how uncooperative R3 is. R3 stated R3, "Felt like (expletive)" and started crying because she thought R3 and V6 were friends." R3 stated she feels very scared and vulnerable because she can't move or take care of herself and is completely dependent on staff. R3 stated sometimes V6 is the only CNA working on the Phoenix Unit, and she is afraid if V6 is mad at R3, she might not go tell other staff she needs help or

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would not go in R3's room if there was an emergency. R3 stated she worries that V6's feelings about her will poison other staff's opinion of R3. R3 stated she had not wanted to tell the Surveyor this because she fears staff retaliation. R3 stated she has a history of experiencing domestic violence, including a former partner shooting her in the neck, causing her to be quadriplegic. R3 stated, "I already have problems with being scared, especially at night, and I startle easy with an extreme reaction to noise." R3 stated other staff members have said things to her such as,"This (Phoenix) is (V6's) hall," which R3 has interpreted to mean it's V6's hall, not R3's hall.

On 8/23/23 at 10:55am, V7, Certified Nursing Assistant (CNA), stated she usually works on the Phoenix Unit, but at times will float to other halls. V7 stated she has witnessed V6, CNA, make racial slurs about R3 behind R3's back, including using the "N" word. V7 stated she reported this a few weeks ago to V2, Director of Nursing, and V3, Assistant Director of Nurses. V7 stated for a few days afterward, V6 worked on a different hall, but V6 is now working on the Phoenix Unit again. V7 stated as far as she knows,V2 and V3 didn't do any kind of investigation or say anything to V6 because V6 is continuing the behavior.

On 8/23/23 at 11:35am, V3, Assistant Director of Nurses, stated on 7/18/23 or 7/19/23, V7 reported V6 was making racial slurs about R3 behind R3's back. V3 stated she did not investigate it, did not inform V1, Administrator, and did not question V6 or R3. V3 stated the decision to move V6 to a different hall for a few days had already been made based on programmatic needs. V3 stated V6 is again back on the Phoenix Unit, but V6 does not provide care for R3, because,"(R3)

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doesn't like her." V3 stated R3 has previously told V3 that V6 is, "A b***h." V3 stated when R3 made this statement, V3 did not ask R3 to elaborate. V3 stated there are other staff R3 does not like, for example new staff or younger in age staff. V3 stated R3 has never reported any abuse allegations toward any staff to V3.

On 8/23/23 at 12:30pm, V4 stated on 7/6/23, she responded to R3's room to assist V5, CNA, in completing care for R3, after V6 had left the room. V4 stated R3 was crying and upset, and V4 stated V5 reported to V4 he had observed that V6, "Had been rough with (R3) during care that day." V4 stated she immediately reported this to V1 and V2. V4 stated she did not know if they started an abuse investigation, but V6 was allowed to work the remainder of her shift that day. V4 stated V6 will now not go into R3's room, and V6 at times is the only CNA on Phoenix, and has to go get CNA staff from other halls if R3 turns on her call light or needs care. V4 stated she has not heard V6 make any racial statements. V4 stated she is concerned about whether or not R3 is getting proper care under these circumstances.

On 8/23/23 at 12:45pm, V5 stated on 7/6/23, he was assisting V6 in caring for R3. They provided incontinence care, and V5 stated R3 always wants a certain perineal spray cleanser to be used, so staff always use the spray per R3's wishes. V5 stated R3 requested the spray be used, and V6 seemed upset and told R3 she wasn't getting the spray that day, but provided no rationale. V5 stated V6 then rolled R3 toward the side of the bed while V5 placed the mechanical lift sling under R3.V5 stated R3 has a lot of nerve pain and staff have to be extra careful when repositioning her, but V6 was not being careful,

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and R3 began yelling that she was in pain, and asked V6 to stop, but V6 continued rolling R3 over. V5 stated R3 was yelling, crying, and cursing, and V6 was being equally loud toward R3.V5 stated he is not sure if V6 was trying to hurt R3, or if it was accidental. V5 stated he told V6 to leave the room, V4 came in the room, and when R3 was comfortably positioned, V5 reported the incident to V4. V5 stated he then assisted R3 with showering, and R3 was crying as V5 tried to console R3. V5 stated he assured R3 the incident would be reported, so after the shower, V5 reported the incident to V1 and V2. V5 stated he is not sure if an investigation was started, but V6 worked the remainder of her shift. V5 stated since the incident, V6 has refused to take care of R3, so CNAs from other halls have been providing care. V5 stated he has not heard V6 make racial statements, but V6 has told V5, "I don't hate her (R3), but I just don't care about her."

On 8/23/23 at 2:05pm, V6 stated she works the 6am to 6pm shift, always on the Phoenix Unit. V6 stated she has been employed at the facility since February 2023, but had previously worked at the facility for a total of eleven years. V6 stated she has never been accused to any type of resident abuse and denied ever having abused any resident. When asked about the 7/6/23 incident, V6 stated R3 is,"Hard to handle," and verbally abuses staff. V6 stated on that date, she and V5 were providing incontinence care for R3 before showering her. V6 denied there was an issue with perineal spray, and denied telling R3 she couldn't have it. V6 stated she was rolling R3 toward her as V5 was putting the lift sling under R3, when R3 suddenly started yelling,"Get off me and stop hitting me." V6 stated she believed R3 was saying that because R3 had told another staff member who no longer works at the facility that R3 was

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trying to get V6 fired. V6 stated she did not say anything to R3, and did not yell back at her. V6 stated she told V5 she was going to leave the room so that R3 could calm down. V6 stated R3 was not crying and did not say anything about being in pain. V6 stated later that day, V2 and V3 told V6 they decided V6 should work a different hall for an undetermined amount of time to give V6 a break from R3, and to give R3 some time to cool off, because "It seemed like there was a personality conflict." V6 stated she worked the rest of her shift that day, and then had a few days off. V6 stated she worked on another hall for a few days when she returned, but had to return to the Phoenix Unit because, "All the residents there were upset and crying because I wasn't taking care of them anymore." V6 stated, "She (R3) must have called (V10, Ombudsman) because she showed up last week and asked me a bunch of questions." V6 stated V10 felt it would be for the best if V6 did not work with R3, so administrative staff told V6 when R3 turns on her light or needs care, other CNA and/or nursing staff are to be summoned to provide the care. V6 stated if staff to resident abuse is witnessed or suspected, it should be immediately reported to V1, V2, or V3, and if they are unavailable it should be reported to the Charge Nurse. V6 stated if a resident is angry and upset with a staff member, the staff member should remove herself and get another staff member to approach the resident. V6 stated she has never witnessed any staff make racist comments about residents, and stated she has never made racist comments about residents.

On 8/23/23 at 3:05pm, V10 stated on 7/7/23, R3 reported to her the incident with V6 that occurred on 7/6/23. V10 stated R3 reported V6, "Was rolling her over and using more force than what

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was required." V10 stated R3 did not identify the incident as abuse, but R3 stated she did think V6's actions were intentional. V10 stated she discussed the incident with V1 and V2, who stated V6 had a few days off, and when she returned would not be back on the Phoenix Unit for an undetermined amount of time. V10 stated R3 called V10 on 8/11/23 to report V6 was working on the Phoenix Unit again.

On 8/23/23 at 3:42pm, V2 stated on 7/6/23, V4 reported R3 said V6 was rough rolling her over, and R3 wanted to speak to V2. V2 said R3 stated her arm got caught under her as V6 was rolling R3 to the side during care. V2 stated R3 said she did not think V6 was intentionally trying to hurt R3. V2 stated V1 was off that day, but she communicated about the incident with him by phone. V2 stated there have been no previous complaints from residents about V6, and that V6 is a good employee. V2 stated she determined, "Nothing inappropriate happened, I felt it was a personality conflict, and that was the end of it." V2 denied any staff had approached V2 about V6 making racial comments about residents. V2 stated V6 was again assigned to the Phoenix Unit with the understanding V6 would not go into R3's room and would have other staff provide her care.

On 8/23/23 at 4:07pm, V1 stated he acts as the facility's Abuse Coordinator. V1 stated in his absence, V2 acts as the Abuse Coordinator. V1 stated the facility's Abuse Policy states abuse is to be immediately reported to him, and if he is unavailable, it is to be reported to V2 or the Charge Nurse, who will immediately report it to him. V1 stated he is to then come immediately to the facility and begin an investigation.V1 stated the accused employee is to be walked out immediately, and is to remain off until the

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investigation is completed. V1 stated he was off on 7/6/23 when V2 called and told him that "(R3) said (V6) was rough with her during rolling her side to side, that (V2) talked to (R3), (R3) said it wasn't abuse, and that was the end of it." V1 stated V2 said V6 denied being rough with R3. V1 stated when he returned to work, he spoke with R3 and R3, "Apologized for lashing out at (V6) and said she wanted (V6) to start taking care of her again." V1 stated since the Surveyor arrived on 8/23/23 asking questions about staff to resident abuse, he decided to start asking staff if they had witnessed abuse, and V2 had, immediately before this interview, told him staff have said V6 has made racial slurs about people of color, but has not made them in front of residents. V1 stated he does not feel this is abuse, but he will be filling out a disciplinary action form on V6. V1 stated V6 takes care of several residents of color, but he does not feel that is a potential problem. V1 stated V10 is in the building a lot, but he does not recall her speaking to him about R3. V1 stated if V10 had reported abuse, he would have immediately followed up on it. V1 stated there have been no previous allegations of abuse against V6. V1 stated V6 is again working on the Phoenix Unit, but other staff are to be taking care of R3, because V6 is, "Scared to go back in there for fear (R3) will accuse her of something." The Surveyor informed V1 there had been allegations V6 made racist comments about R3, and hurt R3 physically and emotionally during care on 7/6/23. V1 stated he would begin an immediate investigation, and would call V6 at home to advise her she would be off until the investigation was completed.

An 8/23/23 Long Term Care Facility Serious Injury Incident and Communicable Disease Report documented, "Alleged abuse-involving (R3). Staff

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involved: (V6). At 4:45pm, (V1) was notified of an allegation of verbal and physical abuse. Investigation initiated immediately.(V6) suspended immediately. Law enforcement notified. Final reportable will be sent within five business days."

On 8/24/23 at 8:10am, V2 stated V1 still acts as the Abuse Coordinator even when off, and is to be immediately notified of abuse, but V2 is to communicate with him and start an immediate investigation and walk out accused staff. V2 stated the residents nurse is to do head to toe skin check to check for signs of injury. V2 acknowledged there was no documentation in V4's Nurses Note to indicate an assessment for injuries was done, and V2 stated, "(R3) gets a daily skin check anyway." V2 stated the 7/6/23 skin check was not timestamped, so there is no way to know if it was done before or after the above referenced incident. V2 stated she did not contact R3's Physician about the allegations of staff to resident abuse.

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On 8/24/23 at 8:30am, V4 stated nursing staff should do a full body assessment on the resident after an abuse allegation has been made. V4 stated she doesn't remember if she assessed R3. V4 stated V2 did not instruct her to do one, nor is she aware of V2 doing one. V4 stated she did not contact R3's Physician.

8/24/23 9:20am, V11, Social Services Designee, stated she has been in the position since May 2023. V11 stated R3 is Quadriplegic as a result of a gunshot wound she sustained during a domestic dispute. V11 stated R3 has recently stated she will accept pastoral counseling for help in dealing with her issues.

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S9999	Continued From page 11 On 8/24/23 at 11:50am, V1 was told about R3's allegation of physical and verbal abuse and verbalization of fearing staff retaliation. V1 stated the initial notification of staff to resident abuse had been submitted to the Illinois Department of Public Health and the investigation was ongoing. The facility's undated Resident Rights Policy documented, "Your facility must provide services to keep your physical and mental health, and sense of satisfaction. You must not be abused by anyone-physically, verbally, mentally, financially, or sexually. Your facility may not threaten or punish you in any way for asserting your rights or presenting grievances." The facility's Abuse Prevention Program Policy, dated 9/29/22, documented," Abuse is the willfull infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods and servicesthat are necessary to attain or maintain physical, mental, and psychological well-being. The facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment. 5. Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the Administrator. Upon learning of the report, the Administrator shall initiate an incident investigation. Upon report of such occurrences, the Nursing Supervisor is responsible for assessing the resident, reviewing documentation, and reporting to the Administrator. Employees of the facility who have been accused of abuse will be removed from resident contact immediately	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002539	A. BUILDING: _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 12 until the results of the investigation have been reviewed by the Administrator or designee. Employees accused of possible abuse shall not complete the shift as a direct care provider to residents. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. 8. External Reporting of Potential Abuse: In response to allegations of abuse, are reported immediately, but not two hours later than the allegation is made, to the Administrator and other officials (including the State Survey Agency). The allegation shall be either called or faxed to the Regional Public Health Office. The Administrator or designee will also also inform the resident or resident's representative and attending physician of the report of an occurrence of potential mistreatment and that an investigation is being conducted. The facility shall immediately contact local law enforcement authorities in the following situations: 1. Physical abuse involving physical injury inflicted on a resident by a staff member or visitor." (B)	S9999		