STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015911	A. BUILDING: _____ B. WING _____	09/07/2023

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BELMONT VILLAGE OAK PARK	1035 MADISON STREET OAK PARK, IL 60302

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S 000	Initial Comments Annual Licensure Survey Facility Reported Incident of 08/16/23/IL163452 - 330.710, 330.4240	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 6 330.710a) 330.710c)2) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services. This requirement is NOT MET as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on observation, interviews and record reviews, the facility failed to follow physician's orders in relation to medication administration for two (R9 and R10) of two residents reviewed for medications. Findings include: On 09/05/23 at 4:10 PM during medication administration, V7 (Licensed Practical Nurse, LPN) was observed preparing R9's medications. POS (Physician Order Sheet) dated 08/10/23 recorded: Xarelto 20 mg (milligrams) one tablet by mouth every evening with dinner; and Tamsulosin 0.4 mg one capsule by mouth every evening after dinner. V7 administered Xarelto and Tamsulosin together. R9 was not observed eating dinner or had eaten dinner at the time medications were given. V7 mentioned, "Dinner is not until 4:30 PM, maybe 5 PM. He has not eaten his dinner yet." V8 was also observed administering medications on R10. Per POS, R10 has orders of Phenytoin Chewable 50 mg chew one tablet by mouth every evening. The Phenytoin chewable was not chewed as ordered. V8 (LPN) verbalized, "We have to follow physician's orders. if its chewable, it should be chewed as ordered." On 09/06/23 at 12:34 PM, V2 (Director of Resident Care Services) was asked regarding medications. V2 stated, "All medications should be administered based on physician's orders. If the order states chewable, resident should be given the pill separately and ask to chew it. If it's after dinner or with meals or with dinner, pills should be given as ordered. If orders state with meals or with dinner, it should be given as ordered, resident is asked to provide choices whether they will take the pills or not. We have to	S9999		

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S9999	Continued From page 2 follow doctors' orders." Facility's policy titled "Medication Management" dated 05/2003 documented in part but not limited to the following: Purpose: To assure safe and accurate supervision, assistance and/or administration of medications by a licensed professional acting within the scope of said license. Policy: 1. All medications will be dispensed through a pharmacy, prescribing physician or/and dentist only. (C) 2 of 6 330.710a) 330.710c)3)A)B)C)D)E)F)G)d)1)2) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or	S9999		

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S9999	Continued From page 3 movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances. E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury. F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. G) Consideration of the feasibility of	S9999		

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S9999	Continued From page 4 incorporating resident handling equipment or the physical space and construction design needed to incorporate that equipment when developing architectural plans for construction or remodeling of a facility or unit of a facility in which resident handling and movement occurs. (Section 3-206.05 of the Act) d) For the purposes of subsection (c)(3): 1) "Health care worker" means an individual providing direct resident care services who may be required to lift, transfer, reposition, or move a resident. 2) "Nurse" means an advanced practice nurse, a registered nurse, or a licensed practical nurse licensed under the Nurse Practice Act. (Section 3-206.05 of the Act) These requirements were NOT met as evidenced by: Based on interviews and record reviews the facility failed to follow their policy and procedures for fall reduction by not reassessing fall risks as needed, not ensuring fall interventions were added or updated in assessments/service-care plans, not ensuring fall interventions were implemented, and not ensuring adequate supervision for a resident at high risk for falls. This failure applies to one of two residents (R8) reviewed for falls and resulted in R8 having repeated falls and sustaining a head injury. Findings include: R8 is an 80-year-old female with a diagnoses history of Anxiety, Dementia, Depression, Hypertension, Overactive Bladder,	S9999		

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S9999	Continued From page 5 Cerebrovascular Accident, Bipolar Disorder who was admitted to the facility 04/21/2023. R8's assessment/service plan dated 04/18/2023 documents she is continent and typically able to go to the bathroom by herself at home; needs no assistance with physical movement and no reported history of falls and is able to self-ambulate independently. R8's progress note dated 04/29/2023 documents R8 was found on her knees next to her bed, she reported she was getting into bed and loss her balance when she fell. Incident report dated 04/29/2023 documents on 04/29/2023 at 4:00 PM R8 had an unwitnessed fall in her room. R8 reported she was getting up from her bed and fell to the floor between her nightstand and the bed. R8 hit her head and obtained a laceration to the back of her head. R8 was sent to Rush Hospital and returned to the facility with a diagnosis of abrasion to scalp. Physician Communication Report dated 04/29/2023 documents R8 was trying to get back in bed when she lost her balance and went down to the floor on her knees; additional orders/instructions include check orthostatic vitals and report readings, keep her well hydrated, keep patient room well lighted, no thrown down rug. Physician Communication Report dated 05/13/2023 documents R8 had an unwitnessed fall. R8 reported she rolled off her bed onto the floor and hit the back of her head on the floor. R8 complained of pain to back of her head. R8 was sent to the hospital for further evaluation. R8's progress note dated 05/27/2023 documents	S9999		

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S9999	Continued From page 6 she had an unwitnessed fall and was observed laying on the floor in her closet with her face forward on the floor. R8's head near the wall, and her arms at her side and both legs extended. R8 was unaware of what led up to fall and reported she hit her head. R8 was sent to the hospital. Incident report dated 05/28/2023 documents on 05/27/2023 at 5:25 PM R8 had an unwitnessed fall. The nurse found R8 lying on the floor of her room by the closet. R8 reported she hit her head. Upon assessment R8 was noted with a small lump to lower right back of her head. R8 was sent to Rush hospital for evaluation and returned to the facility with no new orders. R8's assessment/service plan dated 06/10/2023 documents R8 is continent and typically able to go to the bathroom by herself at home; staff reminds R8 to use assistive devices and requires occasional stand by assistance when unsteady; she is a fall risk with interventions including check her prior to leaving and if no further needs voiced encourage to ask for assistance when needed with PAL (Personal Assistance Liaison) to return frequently, safety room checks with increased frequency due to fall risk, and bed placed next to wall. R8's progress note dated 6/17/2023 documents V22 (Personal Assistance Liaison) called nurse to elevator, R8 was observed sitting on the floor and reported she lost her balance and fell and hit her head, she complained of her head hurting and was sent to the hospital for further evaluation. Incident report dated 06/19/2023 documents on 06/17/2023 at 11:58 AM R8 was observed by nurse sitting on the floor of the elevator. R8 walked into the elevator and lost her balance and	S9999		

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S9999	Continued From page 7 fell when the elevator began to move. R8 reported she hit her head and expressed complaints of pain to her head. R8 was sent to the hospital for further evaluation and returned to the facility with no new orders. R8's Hospital After Visit Summary dated 06/17/2023 documents R8 was seen for a fall with a diagnoses of closed head injury with instructions to schedule an appointment with physician as soon as possible. R8's Fall Risk Assessment completed 06/20/2023 per V2 (Director of Nursing) documents R8's fall risks include being disoriented x2, has had 3 or more falls in the past 12 months, is regularly incontinent and requires assistance, has balance problems while standing/walking, decreased muscular coordination/jerking movements, changes in gait pattern when walking (i.e. shuffling), and requires use of walker. R8's progress note dated 06/26/2023 documents R8 was found on the floor outside of her bathroom and reported she was coming from the bathroom. R8 was only wearing socks on her feet and reported she slipped and fell. R8 reported hitting her head. R8 was sent to the hospital. Incident report dated 06/27/2023 documents on 06/26/2023 at 4:15 PM R8 was observed by nurse sitting on the floor in her apartment. R8 reported she was coming out of the bathroom in her apartment when she fell and hit her head. R8 was assessed by nurse and noted to have a bump to the back of her head. R8 was sent to the hospital for further evaluation and returned to the facility with no new orders. R8 will resume physical therapy as ordered by her physician.	S9999		

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S9999	Continued From page 8 Physician Communication Report dated 06/26/2023 documents the nurse was called to R8's room where she was on the floor. R8 reported she slipped coming from the bathroom. R8 had taken her shoes off with only socks on. R8 was sent out to the hospital. R8's Hospital After Visit Summary dated 06/26/2023 documents she was seen for a fall with a diagnoses of closed head injury with instructions to schedule an appointment with physician as soon as possible. R8's progress notes dated 07/30/2023 documents the Personal Assistance Liaison called nurse to R8's room and was observed by nurse on the floor. R8 reported she was trying to go to the bathroom and fell backwards. R8 was observed with blood on the back of her head. R8 was sent to the hospital. Incident report dated 08/03/2023 documents on 07/30/2023 at approximately 7:08 AM R8 had an unwitnessed fall in her apartment. R8 reported she was trying to go to the bathroom and fell and was observed with bleeding from the back of her head. R8 was sent to the hospital for evaluation. R8 returned from the hospital with 2 staples to the back of her head which will need to be removed in 5-7 days. R8's Hospital After Visit Summary dated 07/30/2023 documents she was seen for a fall with a diagnoses of occipital scalp laceration with instructions to return for staple removal in 5-7 days or follow up with your primary physician. Facility History of Device report for R8's room documents its first use on 08/09/2023.	S9999		

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S9999	Continued From page 9 R8's progress note dated 09/02/2023 documents R8 was found sitting on her floor in her bedroom. R8 reported that she lost her balance. Fall incident report dated 09/02/2023 documents on 09/02/2023 at 6:49 AM R8 was found by a Personal Assistance Liaison sitting on the floor in the bathroom. R8 stated she lost her balance. R8 ambulates using a walker, staff frequently remind her to wait for staff assistance when walking due to unsteadiness, but R8 forgets. R8's assessment/service plan dated 09/06/2023 documents R8 is continent and typically able to go to the bathroom by herself at home; requires wheelchair escort service to meals and activities (she self-transfers); she is a fall risk with interventions including check her prior to leaving and if no further needs voiced encourage to ask for assistance when needed with PAL (Personal Assistance Liaison) to return frequently, safety room checks with increased frequency due to fall risk, and bed placed next to wall. On 09/06/2023 at 1:04 PM V2 (Director of Nursing) stated assessments/care plans are completed upon admission, 30 days after moving in, every 6 months or after a major change of condition. V2 stated frequent falls are considered a major change of condition. V2 stated 2-3 falls within a certain time frame however there is no written policy regarding this. V2 stated a fall with injury would be considered a major change of condition. On 09/06/2023 at 1:28 PM V2 (Director of Nursing) stated R8 was admitted in April 2023. V2 stated R8's most recent fall assessment was completed 06/20/2023. V2 stated R8's most recent assessment/care plan prior to the one	S9999		

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S9999	Continued From page 10 completed 09/06/2023 was 06/10/2023. V2 stated R8's assessment completed 09/06/2023 was sitting in draft status for a period due to changes in billing and was therefore delayed until today. V2 stated the big changes that were pending and needed to be discussed with R8's family included a high score of 18 on fall risk and therefore an increased risk of falls. V2 stated this is why R8's assessment/care plan was not completed timely because R8's billing would increase due to becoming a higher fall risk. V2 stated R8 has needed a wheelchair to ambulate since 07/30/2023 due to having multiple episodes of locking up when using her walker. V2 stated R8 still uses the walker also still requires use of a wheelchair if she's feeling unsteady or having an episode of anxiety, locking up, or becoming unsteady. V2 stated R8's cognitive status is being alert to her name and time and recalls her location though she may need reminders. V2 stated R8 does have Dementia. V2 stated R8 does exhibit confusion or forgetfulness due to her Dementia. V2 stated R8's most recent fall was 09/02/2023. V2 stated R8's assessments/care plans don't include all the fall interventions being applied for R8 however these interventions include being seen by physical therapy, staff frequently keeping her out of her apartment and engaged in activities and groups, and frequent checks when in her apartment. V2 stated staff use assessments/care plans and day to day interaction as a source of implementing interventions. V2 confirmed all R8's falls have been unwitnessed. V2 stated frequency of checks on R8 range from every 10 minutes to every hour and due to staff presence, she is usually in the presence of multiple staff. V2 stated there are times when R8 will go in her apartment and change her clothes or take herself to the bathroom and in that short time when staff are	S9999		

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S9999	Continued From page 11 not necessarily with her is when she has had falls. V2 stated staff should be with R8 whenever she is going to the bathroom. V2 stated staff toilet R8 frequently including before and after meals and in between as well, however due to her dementia and forgetfulness she will frequently walk herself to her apartment and go to the bathroom. V2 stated staff should be with R8 when she attempts to change her clothes or go to the bathroom however staff may be assisting other residents during that time. V2 stated R8 is unattended at certain times. V2 stated R8's fall 09/02/2023 was at 3:25 AM and was unwitnessed. V2 stated during this incident R8 was observed sitting on the floor of her room. V2 stated R8 reported she lost her balance when she fell 09/02/2023. V2 stated seven unwitnessed falls is not acceptable. V2 stated R8 has a floor mat alarm beside her bed to alert staff when she is moving. V2 stated there are times when the fall mat alarm alerted them in time before R8 fell and other times when she had already fallen when the alarm was triggered. V2 stated the facility's setting is the residents home and they cannot be restrained. V2 stated because of R8's risk of falls and supervision needs; she is on a planning list to possibly be relocated to the secure memory care unit due to increased supervision needs. V2 stated R8 does need to be reminded to put on shoes. V2 stated R8's family brought her non-skid socks to help prevent her from falling. V2 stated even with non-skid socks R8 is at risk for falling due to unsteady balance. V2 stated R8's assessment should include all the interventions in place for falls. On 09/06/2023 at 2:45 PM V2 (Director of Nursing) stated R8's bedside mat alarm was implemented 08/09/2023 and it records each time she steps on the mat.	S9999		

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S9999	Continued From page 12 On 09/07/2023 at 2:39 PM V25 (Occupational Therapist) stated per R8's evaluation from 05/01/2023 it indicated that R8 does needs hands on assistance with ambulating because she had a great fear of falling. V25 stated contact guard assistance involves a staff member being close by during ambulation with R8's walker. V25 explained contact guard assistant doesn't include hands on assistance but needs someone close by. V25 stated R8 needs contact guard assistance due to impulsiveness, anxiousness, and fear of falling. V25 stated R8 has required contact guard assistance since June 2023. V25 stated R8's anxiety fluctuates day to day and at times may increase which would cause her to need more assistance such as a wheelchair. The facility's fall reduction/preventative policy reviewed 09/07/2023 states: The purpose of the policy is to "mitigate the risk of injury from falls by identifying risk factors and applying individualized interdisciplinary fall management strategies." "Instructions and individualized interventions to help mitigate the risk of injury from falls will be included for those residents at risk. The care plan will be updated with each assessment to include updated fall management interventions as appropriate" "Once risks are identified, the Resident Care Plan and Approach Chart should contain individualized strategies and interventions to minimize the risk of falls and mitigate injury as much as possible." "Strategies should include interventions that anticipate resident's needs, including supervision and assistance with activities of daily living." "Interventions for Behavioral or Cognitive Related Falls include: Increased staff observation of resident, relocate resident to be in better	S9999		

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S9999	Continued From page 13 line-of-sight of staff, one to one or private Personal Assistance Liaison." (B) 3 of 6 330.2000 Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 700). This requirement was NOT MET as evidenced by: Based on interviews and record reviews the facility failed to follow their policy and procedures for safe and sanitary food preparation by not ensuring prepared food was discarded timely, not ensuring food is stored in a safe and sanitary manner, not ensuring dishware and kitchen equipment was cleaned and stored properly, not ensuring kitchen staff wore head coverings, not ensuring food temps are being monitored regularly, and not ensuring food temping procedures were performed to prevent contamination. This failure has the potential to affect all 83 residents in the facility. Findings include: On 09/05/2023 10:21 AM - 10:45 AM Observed V18 (Server), V19 (Server), and V20 (Dish Washer) working in the kitchen with no hairnet. V21 (Sous Chef) stated staff should be always wearing hairnets in the kitchen. V21 stated he had taken the food temps for the prepared lunch	S9999		

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	IL6015911	A. BUILDING: _____ B. WING _____	09/07/2023

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S9999	Continued From page 14 meal but was unable to provide food temp logs confirming they were taken or taken consistently. V21 stated food temps are not necessarily written down but are taken for all meals. Observed V21 temp the prepared cheese chicken, rice, corn and vegetables, and cream of tomato soup by rinsing the thermometer with water and wiping with a paper towel between taking temps. Also observed V21 only wiping thermometer between temping foods. Observed eight coffee pots with coffee ground residue hanging on the clean dish rack. V21 stated the coffee pots were cleaned and ready for use. V21 stated the coffee pots needed to be cleaned again and the residue should not be left on the clean pots. Observed multiple large containers of prepared salad dressing in the cooler with no dating. V21 stated the salad dressing the dressings were likely prepared on Saturday. Observed a few dozen small cups of prepared salad dressing with no label or date. V21 stated the small cups of salad dressing are prepared every couple of days. V21 stated the salad dressing containers should be dated. Observed a 4.5-pound container of maraschino cherries and an 8.44-pound container of mild salsa opened in cooler without a date. V21 stated the food containers should be dated when opened. Observed outside of ice machine with dust on surface and inside of ice machine with red residue on surface. V21 stated the ice machine should be cleaned whenever observed to be soiled. Observed a personal cup with a straw in it stored in the refrigerator with food used for the facility's residents. V21 stated the cup should not be stored in the refrigerator with food used for the residents. Observed a large box of cut watermelon partially covered with plastic wrap. Observed Lemon Butterscotch pudding dated 08/17, egg custard dated 08/28, Jell-O dated 08/06, mint pudding dated 08/06, and	S9999		

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S9999	Continued From page 15 vanilla pudding dated 08/25 stored in the refrigerator. V21 stated these foods are usually discarded in 4-7 days and should be thrown away. Observed multiple containers of pancake batter dated 08/31 stored in the refrigerator. Observed griddle with an open section of exposed wires covered in extremely heavy buildup. V21 stated the panel that should cover the wiring is missing. V21 stated the heavy buildup is unsanitary and the exposed wire could start an electrical fire in the kitchen. V21 stated the griddle should be cleaned at least weekly. Observed the meat slicer with food particles and uncovered. V21 stated the meat slicer was last used in the morning and will be used again after lunch. V21 stated the meat slicer should be cleaned and covered between uses. 09/07/2023 2:17 PM V28 (Chef Manager) stated for temping ready to eat foods the thermometer should be cleaned with alcohol wipes in between temping food items to ensure the foods are not contaminated. V28 stated after melons have been cut, they should be covered. (C) 4 of 6 330.792a) 330.792b)1)2)3) Section 330.792 Testing for Legionella Bacteria a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. (Section 3-206.06 of the Act)	S9999		

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S9999	Continued From page 16 b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's "Toolkit for Controlling Legionella in Common Sources of Exposure". The policy shall include, at a minimum: 1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system; 2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and 3) A system to document the results of testing and corrective actions taken. This requirement is not met as evidenced by: Based on interviews and record review, the facility failed to develop a water management program policy and failed to implement any procedures of a water management program to prevent the growth and minimize the risk of Legionella or other opportunistic waterborne pathogens within the facility's water systems. This failure affects all 83 residents who currently reside in the facility. Findings include: Reviewed facility's "community census report" dated 09/05/2023 that showed total number of residents as eighty-three. Reviewed maintenance department and facility's testing policies and procedures with no documentation found regarding a water management program that identified specific testing protocols for Legionella and/or other	S9999		

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S9999	Continued From page 17 opportunistic waterborne pathogens. On 09/06/2023 at 11:09 AM, V4 (Building Engineer) appeared confused when surveyor requested facility's water management plan and testing results then said, "we don't have a policy for this, and we have never tested for Legionella." On 09/06/2023 at 11:19 AM, V1 (Executive Director) said "we just recently had the water flushed" then at 12:02PM, V1 added "we don't have to test our water because the facility is not CMS (Centers for Medicaid and Medicare Services) certified for Medicare or Medicaid." Reviewed administrative code regarding Legionella testing with V1 at this time. At 1:55 PM, V1 said "we'll have to develop something." (C) 5 of 6 330.1120a) 330.1120b) 330.1120c) Section 330.1120 Personal Care a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. b) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. c) Each resident shall have clean suitable clothing in order to be comfortable, sanitary, free	S9999		

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S9999	Continued From page 18 of odors, and decent in appearance. This requirement is NOT MET as evidenced by: Based on observation, and interview the facility failed to keep one (R5) of two residents reviewed for personal care free of odors and in decent appearance by failing to timely change R5's incontinence briefs. Findings include: On 9/5/23 at 11:05 AM, surveyor entered the locked unit designated as their memory care unit and asked V13 (PAL/personal assistant liaison) if there was a nurse on the floor. V13 stated, "It's V12 (LPN) today. They are based on the first floor. They only come on the floor when they pass medications but they are not up here, they stay on the first floor. It's just the PALS that stay on the floor. Surveyor asked what a PAL was, V13 stated, "I have no idea." On 9/5/23 at 11:10 AM, surveyor entered the dining area where 19 residents were seated in wheelchairs and some in chairs. There was one activity aide tossing an inflated ball to a handful of residents. The ball appeared to hit some of the resident's heads and other resident's appeared asleep with V12 (enrichment leader/activity staff) continuing to toss the ball with no encouragement from the staff member for residents to participate or to wake up. On 9/5/23 at 11:20 AM, surveyor asked V13 to accompany surveyor to R5's room as it was locked. Surveyor asked the purpose of all the doors being locked, V13 stated, "Everyone here is confused and we don't want them from falling in the hallway". Surveyor asked if they fall in the	S9999		

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S9999	Continued From page 19 room how, anyone will know the resident fell and who would alert them, V13 stated, "All the rooms inside have cameras so if they fell, somebody will radio us to tell us." Surveyor asked who manned the camera's, V13 stated, "I don't know but there's someone always watching it." On 9/5/23 at 11:30 AM, Surveyor approached R5's room and knocked on the door. V13(PAL) and V16 (PAL) were already inside and surveyor asked to be let in to observe care. V16 stated, "We finished already." Surveyor asked if R5 was interviewable, V16 stated, "No he is confused." Surveyor asked to uncover R5's sheets to see if R5 had any injuries sustained from the recent fall. R5's incontinence brief was observed with brown colored fecal matter that protruded through the incontinence brief although V16 stated earlier that she had finished caring for R5. V16 stated, "Sorry I didn't see that." Facility policy dated 7/2003 titled Resident Services states in part, "To ensure care needs are provided for all residents. Personal care shall be delivered as outlined in each resident's service plan. Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene. Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. Each resident shall have clean suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance." (C) 6 of 6 330.4240a) 330.4240b) 330.4240c)	S9999		

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S9999	Continued From page 20 330.4240d) 330.4240e) Section 330.4240 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) (A, B) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 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. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) 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. (Section 3-611 of the Act) This requirement is NOT MET as evidenced by: Based on interview and record review, the facility failed to investigate and report an allegation of abuse by a staff member against one (R5) of two residents reviewed for abuse.	S9999		

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S9999	Continued From page 21 Findings include: On 9/5/23 an annual licensure survey was being conducted along with a facility-reported incident regarding a fall with injury. On 9/5/23 at 10:30 AM, V2 (director of resident care services) stated, "I did the investigation about the fall but nothing about abuse. (V6) was suspended for not reporting R5's fall and she went to claim a worker's comp claim because she said the resident slapped her." Surveyor asked if during her investigation, whether there was any altercation between the resident and V6, V2 stated, "I'm not aware of any altercation." Surveyor asked if she was informed by V9 as to what happened when R5 was on the floor. V2 stated, "Yes she informed me and the executive director about that." Surveyor asked if she was informed if she suspected any potential abuse. V2 stated, "At the time, we termed her for not reporting the fall but we were going to term her for filing a false workman's comp claim." On 9/5/23 at 2:00 PM, V10 (human resource director) stated, "It wasn't initially reported by V6 (former PAL) that the resident had fallen. One of the other PALS (V27) informed me that she witnessed V6 pulling R5 off the floor. V6 called V9 (LPN) who was assigned to the floor and asked if she ever assessed R5. She indicated to me that she didn't assess him because she didn't know he had fallen. V27 (PAL) said she didn't witness the fall but that V6 was pulling R5 off the floor. I then placed a call to V6 to ask why she did not report the fall. She said she didn't report it because she was still in shock from the slap on the face. I terminated V6's employment but I suspended her beginning August 16 and she was termed 8/31/23. R5 is not interviewable. My	S9999		

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S9999	Continued From page 22 honest opinion is that R5 did not slap V6, it was just her way of her trying to cover up the fall incident". Surveyor asked if there was any suspected abuse due to the bruising on the wrist, arms and eventual fracture, V10 stated, "No." On 9/6/23 at 10 AM, V9 (LPN) stated, "At 3 am in the morning I received call from V6 (former PAL) screaming over the radio to come to R5's room. V6 screamed that the resident was combative and to come to floor ASAP. I said I'd be right there and went up there and when I got there V6, R5, and another PAL (V26) were standing in the hall. V6s was yelling that she couldn't believe R5 slapped her. I asked R5 but he did not respond because he has dementia. I said to calm down and tell me what happened and she was holding her face. I didn't see anything on her face that she got slapped. V26 (PAL) then called me and said that R5 was on the floor and she saw V6 trying to pull R5 and was screaming at the resident to 'get up! get up!' I then went to my office and called and reported this to V1 (executive director) and V2 (director of resident care services). I told both of them that V6 was yelling and screaming at R5. After that I saw bruising all over his hand and arm because all of her pulling. I did not see this bruising the night before. V1 and V2 then called me the next morning and they asked me to write a statement." On 9/6/23 at 11:00 AM, V1 (executive director) stated, "I am considered the abuse prohibition coordinator. We did not report an incident of abuse for R5 because V6 was already termed for not reporting the fall and essentially filing a false workman's comp claim." Surveyor asked if they reported any of this to any aide registry, V1 stated, "Because PALS are only considered care givers and not certified nursing aides, we're really	S9999		

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S9999	Continued From page 23 not required to report this to the registry but I see what you mean about future incidents moving forward because V6 will probably be able to work elsewhere." Policy dated 7/2005 titled "Resident Abuse" states in part (but not limited to): "Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents, and development of intervention strategies that include screening, training, prevention, identification, investigation, protection and reporting to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. All employees are expected to follow this policy, failure to do so will result in immediate termination". Residents who have suspicious bruising, particularly of the face arms, abdomen, and shins will have such bruising assessed by nursing and a variance report completed with investigation procedure followed. The facility shall immediately contact local law enforcement authorities in the following situations: physical abuse involving physical injury inflected on a resident by a staff member or visitor. (B)	S9999		