STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008379	A. BUILDING: _____ B. WING _____	C 01/17/2023

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PAVILION ON MAIN STREET, THE	515 NORTH MAIN SANDWICH, IL 60548

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S 000	Initial Comments Complaint Investigation 2310294/IL155243	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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) These requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by staff for one of three residents (R2) reviewed for abuse in the sample of 8. This failure resulted in bruising and R2 crying and distressed into the following day. Findings include: R2's face sheet showed a 75-year-old woman with diagnoses of hemiplegia and hemiparesis affecting the left non-dominant side, need for assistance with personal care, hypertension, osteoporosis and repeated falls. On 1/11/23 at 1:42 PM, R2 was in her room in her motorized chair. R2 became visibly upset when relaying the events of 12/3/22. On 1/11/23 at 10:09 AM, V3 (CNA) said she heard R2 had bruises about a month ago and an agency CNA got walked out. At 10:18 AM, V8 (CNA) said, "There was an issue with R2 about a month ago. A CNA was 'rough' with her. R2 told me that girl (CNA) made her cry. I saw the bruises (on R2). There was one bruise on the right lower arm and two to the upper arm. I asked R2 if she told anyone, and she said she told the nurse. It happened on a weekend before Christmas. I didn't chart the bruises. I heard it wasn't documented. I asked the nurse (V10) what happened." At 10:38 AM, V10 (Licensed Practical Nurse/LPN) said she was in R2's room. V10 stated, "I believe V11 (Medical Records) was in her room too. R2	S9999		

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S9999	Continued From page 3 said a CNA was rough with her, roughed her up when getting ready for bed. I saw the bruises on her arm and was concerned for neglect or abuse. I went straight to V2 (DON). V2 told me they were 'taking care of it.' It didn't happen on my shift, so I didn't document anything. I'm guessing it was already documented and didn't need to start another 72-hour assessment. It was around the first weekend in December. It was about a month ago, the weekend of 12/4 or 12/17/22. It happened on my weekend off so when I came in on Monday, I found out." At 1:42 PM, R2 said her bruises (now gone) were from "that one lady they got out of here." R2 stated, "I was on the toilet and told her she needed to be kinder. She (CNA) started yelling at me louder and louder. My left side is paralyzed, and she (CNA) was trying to get my shirt over my head without unbuttoning it. My left side is paralyzed, and she told me to be quiet as she was going to do it her way and not the way I wanted. She bounced me up against the wall and twisted my right arm. I screamed for her to stop, and she told me I better start listening. I got bruises. She hit me. I was really crying hard. She (CNA) didn't even care they were coming to save me. They escorted her out. I couldn't stop crying. I was afraid she was going to come back and hurt me." At 1:50 PM, R4 (R2's roommate) said, "It all happened so fast. R2 was in the bathroom with the CNA. R2 started yelling and screaming for the CNA to leave her alone. I got out into the hall to get help. R2 was traumatized. She was crying and screaming. It was kind of a big deal. There should be a record of it. She (CNA) was rougher with R2 than she needed to be."	S9999		

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S9999	Continued From page 4 At 3:45 PM, V18 (Registered Nurse/RN) said R2 told her about the incident with the CNA "after the fact." V18 said, "I looked in R2's electronic medical record, and there was no documentation of the incident." At 6:54 PM, V20 (CNA) said on the evening of 12/3/22, she witnessed R2 being forcibly held in a painful position by V22 (CNA) as she (R2) screamed. V20 said V22 did not release her hold on R2 until she (V20) told her to, despite R2's screams. V20 said, "It's a sad, sad situation. On 12/3/22, R2's call light was on. I told V22 the light was on. V22 got on her phone. I again told her she needed to answer R2's light. Shortly after V22 went to answer R2's call light, I heard R2 yelling and screaming. I was at the nurses' station. I ran down to R2's room. I don't remember the CNA's name. R2 was sitting on the toilet and her right buttock was halfway off the seat. V22 had R2's right side pushed against the bathroom wall and her left (paralyzed) arm extended above her head. R2 can't move her left side and you must be careful with it. She (V22) hit her (R2's) right side on something. The grab bar and toilet paper holder were on R2's right side. R2 was visibly in pain, crying, had tears and was still screaming at the CNA. You must put R2's left arm in a top first and the CNA wanted to put it over her head. R2 will tell you how to take care of her and dress her. She (V22 CNA) roughed her up pretty good. R2 had bruises to the right side, her wrist, and arm later that night. I told V21 (Registered Nurse/RN) about it and V21 notified V1 (Administrator). V21 talked to me about it and took notes. I wrote a statement and gave it to V21. No one else ever asked me about it. R2 was upset and still shook up the next day too. A day or so later R2 said 'That lady hurt me.' You could see it in her face. She (R2) was so upset V22 hurt	S9999		

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S9999	Continued From page 5	S9999		

her. This was hands down 100% abuse. I walked in on V22 hurting her. You can't ignore them (residents) and just do stuff your way. She had the right to be protected and be safe. That's our job, to advocate for them. R2's roommate was in the room at the time and heard everything."

At 11:00 PM, V21 (RN) said she wasn't sure of the date of the incident with R2, but it was on the evening shift. V21 said, "I usually work nights and I picked up an evening shift that day." V21 said she was notified by V20 (CNA) of an abuse incident between V22 and R2. V21 said she assessed R2 and interviewed her. V21 said R2 was alert and oriented. R2 had bruises to both arms. V21 said, "I was taken aback when V1 told me not to document anything in R2's record or anywhere else. I didn't document anything. I didn't want to get fired. I assumed it would be taken care of. It should not have happened. R2 was very upset. She was very emotional and crying. R2 told me she didn't deserve to be treated that way. I have no doubt this situation occurred. I feel it will continue if it's not documented, reported and investigated. If something like this is going to be covered up, what else could be covered up?"

At 9:15 AM, R2 said the CNA was "hitting" her. R2 said she didn't want to talk about it anymore. R2 said, "They took good care of me after the fact."

At 9:50 AM, V19 (RN) said R2 told her a CNA was "super rough" with her. She said she was "attacked" by a CNA.

At 10:19 AM, V22 was unable to be contacted. V22's contact phone number was called and was disconnected. The facility was not able to obtain a working phone number, birthdate, social security

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S9999	Continued From page 6 number or perform a Healthcare Worker Background Check as V22's social security number was not available to the facility. V22 was contracted through an agency and background check details were not available. On 1/13/23 at 10:55 AM, V4 (RDO) said V2 was "new" and R2's incident was reported "as a behavior." R2 didn't like the CNA and had a "preference." At 10:55 AM, V2 confirmed 12/3/22 was the only second shift V20 and V21 worked together. At 1:20 PM, V25 (CNA) said she worked the day after the "incident happened" with R2. V25 said, "I didn't see any bruises, but they were maybe on her arm. I got upset. R2 was upset, crying and saying she wanted to leave the facility. I asked if someone knew what happened and the nurse was aware of what happened." The facility's 5/2019 Abuse, Neglect Exploitation Policy showed abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This assumes that all instances of abuse of all residents, irrespective of any mental or physical, even those in a coma, cause physical harm, pain or mental anguish. Treating any resident in a manner that does not uphold a resident's sense of self-worth and individuality dehumanizes the resident and creates an environment that perpetrates a disrespectful/or potentially abusive attitude towards the resident(s). R2's electronic medical records showed no documentation of the 12/3/22 incident or subsequent bruises. There was no	S9999		

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S9999	Continued From page 7 documentation of R2's physician notification of the incident. R2's 12/12/22 facility assessment showed she was cognitively intact. This assessment showed R2 required extensive assistance to dress, toilet, personal hygiene and transfers. R2's care plan showed she had decreased upper body dressing skills related to medical complexities. Interventions for dressing included to assist resident to fasten/unfasten shirt, instruct resident to put each arm into sleeves and bring front together, and provide assistance as needed for any step she cannot complete. R2's Activity of Daily Living (ADL) care plan showed to allow sufficient time for dressing and undressing. R4's 10/28/22 facility assessment showed she was cognitively intact. Time reports for V20 (CNA) and V21 (CNA) showed the only date they worked together on second shift was 12/3/22. (B)	S9999		