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	IL6014955	A. BUILDING: _____ B. WING _____	C 04/13/2023

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S 000	Initial Comments Facility Reported Incident of April 13, 2023 IL158559	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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 observation, interview, and record review, the facility failed to prevent the verbal/mental abuse of a facility resident, failed to report an allegation of abuse per the facility abuse policy, failed to suspend an alleged abusive staff,	S9999		

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S9999	Continued From page 2 and failed to interview all potential witnesses while investigating an allegation of abuse These failures resulted in psychosocial harm to R1 as exhibited by crying, shaking, fear, feeling intimidated, vulnerable and threatened, and experiencing ongoing emotional anguish after the abusive event. This applies to 1 of 3 residents (R1) reviewed for abuse in a sample of 4. The findings include: Face sheet, dated 4/12/23, shows R1's diagnoses includes closed fracture with routine healing, chronic migraine, anxiety disorder, muscle weakness, difficulty walking, mood disorder, major depressive disorder, and osteoarthritis. MDS (Minimum Data Set), dated 3/27/23, shows R1's cognition was intact. On 4/11/23 at 11:57 AM, R1 stated on 4/2/23, V2 (CNA - Certified Nursing Assistant) rudely "flung" her room door open, which slammed against her dresser drawers, and walked into her room. R1 stated V2 kept loudly saying, "It's gonna be a good day! Yes it is! And I am going to do what I have to do. It's gonna be a good day!" R1 stated she reminded V2 that R1 was to receive a shower that day, and V2 replied loudly, "You're not getting a shower! You are not scheduled today! " R1 stated she had not had a shower in five days. R1 stated she reminded V2 when V2 initially approached R1 to take a shower, R1 had a migraine headache and asked to postpone her shower until she felt better later. V2 yelled at R1 stating, "I'm not going to give you a shower!" V2	S9999		

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told R1 because she declined earlier due to her migraine, R1 refused and V2 was not giving R1 a shower. R1 stated V2 put her pointer finger within two feet of R1's face, shook it, and yelled, "You aren't getting an extra shower! I have things to do and you aren't getting a shower!" V2 yelled, "I'm going to have a good day today and I'm not doing an extra shower!" R1 stated, "It was abusive! I was shaking!" R1 stated she felt like she was being threatened, and was not going to continue to ask V2 for a shower because she was unsure what would happen next. R1 stated, "She could have hit me." R1 stated she then asked V2 to provide her with clothes from her closet. V2 opened R1's closet swiftly and stated, "Well everything is here is dull!" R1 replied her sons were doing the best they could, and V2 responded, "Well they aren't taking you home so I guess I understand!" R1 began to cry during the interview, and stated V2 tried to make R1 feel like her sons did not care about her. R1 stated she cried when V2 told her that her family would not take her home. R1 stated V2 kept telling R1 she had seniority at the facility, and R1 felt like V2 was trying to intimidate her not to "get out of line." R1 stated she was very upset, shocked, and felt disgusting, angry, emotional, sad, and vulnerable. R1 stated she shook the rest of the day, and began to cry again during the interview. R1 stated, "I was afraid of her! It was trauma I will be honest. There are times I still cry because of what she said to me about my family not wanting me. It comes back to me." R1 stated she was unsure of what to do next and did not know who she could trust. R1 stated she believed V4 (Nurse) heard the yelling from the hallway and entered R1's room. R1 stated she told V4 everything that happened, and she told V4 she did not want V2 taking care of her again. R1 stated she was very angry, shocked, and crying

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at the time, and V4 held her hand. R1 stated V5 (Social Services Director) came and talked to her the next day, and R1 told her V2 had been abusive toward her. R1 stated, "Someone in that line of work should not be working in any facility taking care of patients like that."

On 4/11/23 at 10:25 AM, V4 (Nurse) stated on 4/2/23, she was working with V2 earlier in the morning, and V2 was talking back to V4 during the shift. V4 stated later she was in another resident's room when she heard V2 yelling in R1's room being disrespectful, rude, and loud, directed toward R1. V4 stated she heard V2 and R1 were arguing about showers. V4 stated she went to R1's room and asked V2 to leave the room. V4 stated R1 was shaking. V4 stated, "It was abusive." V4 stated she had never seen anyone talk like that toward a resident. V4 stated R1 was crying when V4 was in the room. V4 stated she reassigned V6 (Certified Nursing Assistant/CNA) to R1's care, and told V2 she would no longer care for R1, and to not go into R1's room. V4 reassigned V2 to another resident. V4 stated V2 denied raising her voice and/or being rude to R1, and told V4 she was only acting that way toward V4. V4 responded she had just gone to R1's room because V2 was yelling at R1. V4 stated she texted V3 (Director of Nursing) immediately to tell her what had happened. V4 stated when she returned to R1, R1 told V4, "I am afraid if she comes back." V4 stated R1 told her V2 pointed her finger in R1s face and stated, "You don't have anywhere to go! Your family would not take you!" V4 stated she left the room and reassigned V6 (CNA) to R1 and R1 was crying when V4 returned to R1 saying, "I have a place to go... Nobody likes me here!" V4 stated R1 was scared and upset. V4 stated, "It was abusive." V4 stated she reassigned V6 (CNA) to R1's care and told V2

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she would no longer care for R1 and to not go into R1's room. V4 reassigned V2 to another resident. V4 stated she texted V3 (Director of Nursing) immediately to tell her what had happened. V4 stated V2 later walked out of the facility and abandoned her shift.

On 4/11/23 at 11:27 AM, V6 (CNA) stated on 4/2/23, V4 asked V6 to switch resident assignments and work with R1. V6 asked what happened, and V4 stated V2 yelled at R1. V6 stated V4 asked V6 to go check on R1 and talk to her so R1 could calm down. V6 stated when she introduced herself to R1, R1 began crying. R1 told V6, "'I am worthless! They treat me like trash!'" V6 tried to calm R1 down, and told R1 she would give her a shower after she removed residents from the dining room from breakfast. V6 stated when she took R1 to the shower room, R1 began crying again and stated, "(V2) abused me verbally!" R1 told V6 that V2 told R1 that her family would not take R1 back, and they were going to dump R1 at the facility. R1 told V5 that R2 stated R1's clothes were like rags. V6 stated when she saw R1 later to give her lunch, R1 began crying again, and asked if V2 was still at the facility. V6 stated R1 told V6 that she was going to make sure she reported V2 to the Administrator, and V6 gave R1 the Administrator's name. V6 stated she showered R1, and she and R1 saw V2, approximately 1-1.5 hours after V6 was re-assigned to R1, sitting at a hallway kiosk completing computerized charting. V6 stated no one from the facility interviewed her regarding R1's allegation of abuse on 4/2/23.

Nursing progress note, date 4/3/23, shows R1 asked to speak to V5 (Director of Social Services.)

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On 4/11/23 at 12:54 PM, V5 (Director of Social Services) stated R1 asked V5 to see her on 4/3/23. V5 stated R1 wanted to document the episode, which occurred between R1 and V2 on 4/2/23. V5 stated R1 reported V2 stormed in her room, they argued about R1's shower, and V2 pointed her finger in R1's face and told her she did not deserve an extra shower. V5 stated R1 reported V2 told R1 her clothes were "dull", it was no wonder her family did not visit R1, and R1 was not going home. V5 stated R1 reported she was sad and R1 was teary-eyed and shaking during the interview.

Written statement, collected by V5 and signed by R1 on 4/3/23, shows, "Patient had detailed notes.... [V2] came 'busting' into the room and the door hit the dresser. [V2] asked how [R1] was doing and the patient said she was excited to be getting her shower. [V2] replied, 'Well you're not getting one girl!' and was pointing in her face with her finger. Patient stated it is her shower day and her schedule is on her board. [V2] said you ain't getting one you refused. Patient stated 'I never refused I asked to wait a bit as I had a migraine.' [V2] said 'I marked you refused. If someone else wants to give you a shower then they can, but I'm not.'" Patient asked for assistance in dressing and [V2] went to her closet and said, 'These clothes are all dull. No wonder your family doesn't visit and you're not going home."

On 4/12/23 at 11:45 PM, V7 (Physician) stated his expectation at the facility was for the residents to be free of abuse. V7 stated R1 was reasonably upset, because her son told her she was not safe to return to home from the facility where she previously lived independently. V7 stated R1 was not happy abut the change, and "this is a sore

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spot with her that she can not go home." V7 stated R1 had episodes of crying when she was first admitted to the facility because of pain and physical limitations, but R1's mood had improved since because she was making progress, and crying was not normal for her in recent weeks.

On 4/11/23 at 1:43 PM, V3 (DON) stated on 4/2/23 at 10:40 AM, she received a call from V4 telling V3 that V2 walked off of her shift after confrontations with V3 and R1. V3 stated during that call, V4 reported V2 and R1 had a loud verbal exchange, V4 went to R1's room to remove V2, and V2 was reassigned to another resident. V3 stated she was unsure if it was reported to her R1 experienced V2 pointing her finger in R1's face, R1 was told her family would not visit and would not take her home, or R1 was crying/shaking. V3 stated the abuse investigation regarding R1 and V2 was initiated on 4/3/23 after V5 (Social Services Director) initiated a grievance on R1's behalf.
V3 stated she did not interview V6 during her abuse investigation.

Initial Report IDPH (Illinois Department of Public Health), dated 4/3/23, shows the initial report of R1's allegation of abuse was sent to IDPH on 4/3/23 at 3:50 PM.

Facility time sheet, dated 4/2/23, shows V2 began work at 6:10 AM and V1 (Administrator) punched her out of the facility at 11:00 AM.

On 4/11/23 at 2:42 PM, V1 (Administrator) stated the allegation abuse should have been reported to IDPH no later than two hours after the allegation. V1 (Administrator) stated he concluded the abuse of R1 was unsubstantiated in the facility investigation because V4 did not

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hear exactly what V2 yelled at R1, and V2's fingerpointing was not witnessed. V1 (Administrator) stated V2 should have been immediately removed from the facility and not reassigned to other residents. V1 stated he punched V2 out on the time clock when he received notice from V3 she left the facility, because V2 walked out of the facility without punching out.

Review of facility abuse investigation, initiated 4/3/23 and finalized 4/7/23, fails to show V2 was immediately suspended once the alleged abuse occurred. The investigations fail to show V6 was interviewed as a witness regarding R1's allegation of abuse.

R3's Minimum Data Set (MDS), dated 3/17/23, shows R3's cognition was intact. On 4/11/23 at 11:10 AM, R3 stated V2 "Can be rough as hell." R3 stated he heard V2 be curt with residents on a regular basis.

R4's MDS, dated 4/3/23, shows R4's cognition was intact. On 4/11/23 at 11:52 AM, R4 stated V2 could be a little bit rude/mean.

Final Facility Investigation Report, dated 4/7/23, shows on 4/3/23 "(R1) reported she was denied her scheduled shower, and had negative verbal statements and physical gestures (non-contact) directed toward her from the CNA assigned to provide her care." The investigation shows V5 (Social Services Director) interviewed R1 who stated V2 (CNA) "busted" into her room and asked how R1 was feeling. R1 responded she was excited to be receiving a shower and V2 responded, "Well you're not getting one girl." R1 stated V2 was pointing her finger in R1's face. The report shows R1 told V2 it was her shower

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S9999	Continued From page 9 day, but V2 replied R1 had refused due to a migraine. R1 then stated she asked for assistance dressing, and V2 told R1 that her clothes were "dull" and it was no wonder why R1's family did not visit R1. R1 stated V2 stated R1 was not going to go home. Review of the final investigation documents showed V1 interviewed V2 and V2 denied the allegations. The documents show V3 (Director of Nursing) interviewed V4 (Nurse), who stated she overheard a loud verbal exchange between V2 and R1. V4 stated she was unable to determine if V2 pointed her finger at R1. V4 stated when she questioned V2 about the loud verbal exchanged, V2 refused to answer, and exited the facility. V4 stated she notified V3 of the incident. The final report shows the allegation of abuse was not substantiated. Facility time sheet, dated 4/2/23, shows V2 began work at 6:10 AM, and V1 punched her out of the facility at 11:00 AM. Facility Abuse, Neglect and Exploitation Policy, revised 10/2022, shows, "Residents have the right to be free from abuse, neglect, mistreatment, misappropriation of resident property, and exploitation...." The policy shows the abuse definition includes, "Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish... 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." The policy shows mental abuse definition includes humiliation, harassment, and withholding of treatment or services. The definition of verbal abuse includes "Any use of oral, written or gestured language that willfully includes	S9999		

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S9999	Continued From page 10 disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents...."Alleged violations involving abuse... should be reported as soon as practical but not later than two hours after the allegation is made.... Such alleged violation shall be reported to "i. State Survey Agency; and ii. Adult protective services..." "Protection of Resident. Upon learning of alleged abuse... the Administrator or supervisor on duty should attempt to take necessary steps to verify residents are protected from subsequent episodes of abuse.... If an allegation of abuse... is made against an associate or associates, the accused individuals should be suspended until the matter has been investigated and a determination made as to the underlying allegation." The policy shows, "Internal Investigation... a. The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community." (B)	S9999		