| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007934 | A. BUILDING: _____ B. WING _____ | 03/09/2023 |

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| ELEVATE CARE PALOS HEIGHTS | 12550 SOUTH RIDGELAND AVENUE PALOS HEIGHTS, IL 60463 |

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| S 000 | Initial Comments<br><br>Annual Health Certification | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Requirements were not met as evidenced by:<br><br>Based on observations, interviews and record review, the facility failed to protect a cognitively impaired resident from physical and emotional abuse by a staff member who forcefully pushed the resident in her wheelchair and shouted at the resident out of frustration which caused the resident to be fearful of the staff member, emotionally distraught and intimidated; and facility failed to follow their policy on abuse prevention. This failure affected one (R81) of 5 residents reviewed for abuse from a sample of 37 residents.<br><br>Findings include:<br><br>R81 is a 76-year-old female with birthdate of 06/15/1946. She admitted to the facility on 09/13/2022 and has a past medical history not limited to Weakness, Lack of Expected Normal Physiological Development in Childhood, Non-ST Elevation Myocardial Infarction, Syncope and Collapse, and Difficulty in Walking.<br><br>On 03/06/23 at 11:54 AM while outside of R81's room, surveyor overheard V8 (Certified Nursing Assistant/CNA) being verbally abusive to R81 regarding a telephone cord being tangled up in her wheelchair. Surveyor then observed V8 (CNA) forcefully push R81, who was seated in her wheelchair, from next to her bed forward | S9999 | | |

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| S9999 | Continued From page 2<br>towards the room door. V8 (CNA) then said loudly and with continued frustration, "I'm still trying to get the cord untangled", went behind R81's wheelchair, then proceeded to lift the wheelchair from behind and turned it so R81 was now facing the doorway. Surveyor observed R81 at this time while sitting near doorway and she appeared frightened. At 11:57 AM, V8 (CNA) then moved R81 from the area near the doorway back to the area next to her bed. Upon leaving R81's room, when asked if staff should talk to a resident in that manner with such frustration, V8 (CNA) said "no and I'm sorry". V8 (CNA) was informed that she should apologize to the resident and not to the surveyor. V8 again apologized to surveyor but did not observe V8 (CNA) apologize to R81. At 11:58 AM, surveyor reported incident to V9 (Licensed Practical Nurse) who was working on the unit. At 12:15 PM, observed V8 (CNA) assisting other staff members pass lunch trays on this same unit.<br><br>On 03/06/2023 at 12:22 PM, V1 (Administrator) said abuse protocol is for the alleged perpetrator to be removed immediately. V1 then said regarding the alleged incident with V8 (CNA), that she was just told about it and V8 is now gone. At 1:21 PM, V1 (Administrator) provided R81's initial abuse report submitted to the department that indicated surveyor reported V8 seemed frustrated and was not speaking to R81 appropriately. Report stated that V8's (CNA) statement was taken but was not included within the report. Received V8's statement from V1 (Administrator) which indicated V8 was having a hard time getting cords loose from R81's wheelchair. Statement also indicated V8 could not recall speaking inappropriately to R81, but was probably speaking loudly because she could not hear R81. | S9999 | | |

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| S9999 | Continued From page 3<br><br>On 03/06/2023 at 1:55 PM, interviewed R81 in her room. When asked if she had ever experienced poor staff treatment and/or abuse prior to today, R81 said "I just wanted to get it done". Then added, "I was scared of that one that was in here, there's one that always yells but so long as they help me, I'm not going to say anything". At 2:03 PM, R81 who appeared frustrated added "if they want to yell, then I just let them go ahead and yell".<br><br>On 03/06/2023 at 2:15 PM, V1 (Administrator) said that she knows V8 (CNA) from a previous facility and V8 personally took care of her loved ones. V1 added that she knows V8 talks loudly because she is hard of hearing but has never know of V8 (CNA) to speak in this alleged manner. Reviewed V8's personal file which showed a physician assessment dated 06/29/2022 that documented, "patient denies any hearing loss". Reviewed V8's (CNA) training logs that showed she last completed abuse and neglect training on 11/29/2022.<br><br>On 03/07/2023, reviewed R81's MDS Section C - Cognitive Patterns dated 02/13/2023 that showed her Brief Interview for Mental Status (BIMS) score was "11" out of 15 which indicated moderate cognitive impairment. Also reviewed R81's current plan of care which did not show an implemented care plan to prevent R81 from being abused.<br><br>On 03/07/2023 at 11:21 AM, when talking with R81 regarding the incident with V8 (CNA) from previous day, R81 said "they come in and don't tell us who they are. They make me want to not care anymore". | S9999 | | |

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| S9999 | Continued From page 4<br><br>On 03/07/2023 at 11:31 AM, V12 (Licensed Practical Nurse) said she started working at facility one month ago and completed abuse training during her orientation. When asked to name specific types of abuse, V12 said "verbal, financial, and physical are the only ones I know of".<br><br>On 03/07/2023 at 01:39 PM, V19 (Certified Nursing Assistant) said she had just completed abuse training a week ago. When asked to name specific types of abuse, V19 said "verbal, physical and that's all I know of".<br><br>On 03/07/2023 at 01:49 PM, V20 (Certified Nursing Assistant) who was assigned to the 400 unit said, "her last abuse in-service was last night" and types of abuse are "verbal, sexual, physical, and abuse done to others".<br><br>Reviewed Facility Reported Incident Final Abuse Reports for the last year until present and noted the following:<br><br>On 02/24/2022, a male (deceased) resident complained of being physically abused by a certified nursing assistant. Report indicated the staff member was interviewed and denied physically abusing the resident. The allegation of physical abuse was not substantiated by V1 (Administrator). Reviewed resident's MDS Section C - Cognitive Patterns while at facility dated 10/22/2022 that showed his Brief Interview for Mental Status (BIMS) score was "11" out of 15 which indicated moderate cognitive impairment.<br><br>On 03/09/2022, a surveyor reported an allegation of verbal abuse made by R75's spouse. Report indicates the residents involved were not interviewed due to cognition and the staff | S9999 | | |

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| S9999 | Continued From page 5<br>member involved denied verbally abusing any resident during her interview. The allegation of verbal abuse was not substantiated by V1 (Administrator).<br><br>On 03/27/2022, when interviewed by a surveyor about an incident that occurred on 11/24/2021, R37 said she was verbally and physically abused by V28 (Certified Nursing Assistant). R37 then stated that she was informed V28 was no longer employed at the facility. Report indicated the facility attempted to contact V28 for an interview but was unable to reach her. The allegation of verbal and physical abuse was not substantiated by V1 (Administrator). R37's Brief Interview for Mental Status (BIMS) score dated 01/11/2023 showed "14" out of 15 which indicated no cognitive impairment.<br><br>On 09/27/2022, R37 complained of being physically abused by a certified nursing assistant. Report indicated the staff member was interviewed and denied physically abusing R37. The allegation of physical abuse was not substantiated by V1 (Administrator).<br><br>On 02/13/2023, R29 (hospitalized since 03/06/2023) complained of being verbally abused by a certified nursing assistant. R29's Brief Interview for Mental Status (BIMS) score dated 03/05/2023 showed "15" out of 15 which indicated no cognitive impairment. Report indicated the staff member was interviewed and denied verbally abusing R29. The allegation of verbal abuse was not substantiated by V1 (Administrator).<br><br>On 03/08/2023 at 09:50 AM, V1 (Administrator) was interviewed by the survey team regarding the outcome of her abuse investigations reviewed | S9999 | | |

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during survey. When asked how V1 concluded the allegations were all unsubstantiated, including those allegations made by residents who were cognitively intact, V1 (Administrator) said "it's their word versus the staff because that's how I was trained".

On 03/08/2023, V1 provided final investigation report for R81 that did not indicate the result of investigation findings, whether abuse was substantiated or not. Report indicated surveyor reported to V9 (LPN) that V8 (CNA) was "speaking loudly" to R81 and indicated that V8 "did not mean to sound frustrated she was trying to get her wheelchair untangled". Report also indicated V8 (CNA) was not frustrated with the resident but only with the cords restricting the wheelchairs mobility and that V8 did not intend to show any willful frustration towards R81. Report concluded with, "the facility will do one on one abuse and customer service training with V8 prior to her return to work, will closely monitor V8 upon return by conducting random checks on residents she cares for".

On 03/08/2023 at 1:35 PM, requested R81's initial and most recent abuse/neglect screen and abuse care plan from V7 (Social Services Director) who said screenings should be completed upon admission, quarterly and with any allegations. At 2:39 PM V7 said the facility began screening residents for abuse or neglect and implementing abuse care plans as of 01/01/2023. At 2:44 PM, V7 (Social Services Director) said R81 was not screened for, or care planned for abuse upon her admission on 09/13/2022. V7 then provided R81's abuse/neglect screen dated 03/07/2023 and abuse care plan with revision date or 03/08/2023.

On 03/09/2023 at 1:48 PM, when asked if there is

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| S9999 | Continued From page 7<br><br>required training to be the abuse coordinator, V1 (Administrator) said "no, but I do yearly abuse training courses on-line". When asked when she last completed abuse training, V1 said "I'll have to get back to you with the date". At 2:00 PM, V1 indicated her last abuse prevention and reporting training was completed on 07/31/2022.<br><br>Reviewed Abuse Policy last revised 10/24/2022 that showed the facility prohibits abuse and neglect by staff done by orientating and training employees on how to deal with stress and difficult situations. Policy defines abuse as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means and provides examples of mental and verbal abuse include but not limited to "yelling or hovering over a resident, with the intent to intimidate". Policy indicated under "establishing a resident sensitive environment" will be accomplished through:<br><br>"Resident Assessment: as part of the resident's life history on the admission statement, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary".<br><br>(B) | S9999 | | |