STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Certification and Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.3240c) 300.3240e) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 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) 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) 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) These requirements were not met as evidenced by: Based on observation, interview and review of records, the facility failed to protect resident's right to be free from physical abuse and mental abuse for 3 out of 3 residents (R23, R24, R42) for a total of 18 residents reviewed for abuse. These failures resulted in1 resident (R23) suffering pain	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 after being roughly pulled during care by health care personnel (HCP) with a diagnosis of Right upper leg / hip fracture and (R24, R42) being spoken to rudely and refusing to provide assistance with ADL care causing mental anguish to 2 residents (R24, R42). Findings include: R23 is 78 years old, re-admitted on 03/17/2023 with medical diagnosis of displaced fracture of greater trochanter of right femur. R23 has a brief interview of mental status of 15 that means R23 cognition is intact. On 05/03/2023 at 02:11 PM, V15 (State Ombudsman) said the facility was ignoring an incident that happened with R23, the alleged victim, and V13 (Certified Nursing Assistant / Agency), the alleged perpetrator. V15 forwarded an email that in part reads: V13 screamed at R23 despite R23 asking V13 to be gentle. V13 was being rough with R23. V13 still works in the facility after incident. Another email dated 05/03/2023 at 05:11 PM was sent by V15 reiterating the facility was ignoring her (V15). It reads: They (facility) not ever saw the need to return my (V15's) call. On 05/03/2023 at 02:42 PM. V13's schedule and contact information was requested from V1 (Administrator). V1 said V1 would check and get back to give update. On 05/03/2023 at 02:45 PM. R23 said, "Let me make this clear, this is how it happened. V13 (Certified Nursing Assistant) came inside my room and told me that she will change my diaper then V13 left room. After that 2 therapist (V26/PT and V27/OTA) came in because I was scheduled	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

to have therapy. They offered to change my diaper because I was wet. I refused because I feel uncomfortable with male therapist changing me. About 10, 15, or 20 minutes later V13 came back really upset screaming and said that I should have let those 2 therapists (V26 and V27) change me. V13 then pulled my legs apart really hard making it really hurt bad (R23 was grimacing). V13 was rough handling me while changing me. I think she hurt me on purpose because she was upset that I did not allow the 2 therapists to change me. So, I was crying during therapy and the 2 therapists asked me what was wrong. At first, I told them (2 therapist) it was nothing. Then V24 (Therapist / Rehab Director) came and asked me and I told her what happened. V24 told me that I need to report it." R23 said, "I felt bad, this same thing happened to me in another place (Nursing Home), they told me that's just how that person acts. I feel traumatized."

On 05/04/2023 at 09:31 AM. V1 (Administrator) stated she only interviewed random residents. When asked why the therapist who was present during the incident was not interviewed. V1 said, "I will look on it." Again, V1 was asked the same question. V1 again said, "I will look on it."

On 05/04/2023 at 09:51 AM. V24 (Director of Rehab and Therapy) said, "R23 was relatively new during this incident. V26 (Physical Therapist) and V27 (Occupational Therapist Assistant) went into R23's room. R23 said that she needs to be change. V26 and V27 offered to change her but R23 said I would rather have a woman. The call light was turned on and one of the therapists went to go find a certified nursing assistant. Both V26 and 27 left the room. Twenty minutes later, V13 (Certified Nursing Assistant /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

Agency) went to R23's room but both V26 and V27 had already left. After V13 care, R23 said V13 was abrupt and rough in V13's care. R23 told V24, 'V13 makes me feel uncomfortable.' R23 was crying a bit while she was telling me (V24) about V13. R23 was in significant pain at that time. R23 has right hip fracture, hip replacement. Precautions needed with hip fracture medical diagnosis includes not crossing legs, don't pull legs wide apart, and no bending or leaning forward. I agree it is different when a person has physical pain and being handled correctly compared to when a person has physical pain and also emotional or psychological pain during care by V13, I cannot argue with that. I think V13 was upset because V13 just changed R23 and then V13 needed to change R23 again because R23 is scheduled for therapy. I know that is not a good reason because it is what they are here for. The staff that has primary duty to do incontinence care are the CNA (Certified Nursing Assistant). Although therapist like PT (Physical Therapist) or OT (Occupational Therapist) are also trained to perform incontinence care."

On 05/04/2023 at 10:14 AM, with V26 (Physical Therapist) and V27 (Occupation Therapist Assistant), V26 said, "R23 was in a lot of pain because of her medical diagnosis. R23 has fracture and has a lot of pain. She (R23) often feels uncomfortable. We had already left (R23's room) before V13 performed bedside care (to R23) but we were informed by V24 that R23 felt that V13 was abusive and was rough."

On 05/04/2023 at 09:43 AM this surveyor left a message for V35 (Orthopedic Doctor). At 01:40 PM, V36 (Nurse Practitioner) calling for V35 said, "R23 has minimal displace fracture, R23 requires restrictive weight bearing positioning and I would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

not extend her leg. Absolutely R23 has pain because of the fracture." V36 did not order pain medication but R23 currently has an order for pain medicine.

On 05/05/2023 at 11:17 AM V13 (Certified Nursing Assistant) said before any questions were asked, "I deal with too many clients and work too much. I cannot remember, I do not want to get upset with you." V13 then said, "I worked on the floor and R23 was one of my residents. We were very busy that day. I think it was morning, R23 was so sweet, very needy but real nice. I went to see R23 and she said she has therapy later. I told R23 why we don't get her washed up and leave her pants half on. Later I went back to R23's room and told her that I was not available and told R23 that the therapist can change her (R23). Because everybody has a slot and everybody has a schedule, I need to take care of everybody not just R23. R23 did mention that therapist tried to change her." V13 was asked twice to describe what happened during incontinence care. V13 answered twice, "Nothing happened." This surveyor asked V13 to describe what she can remember and had no implication to anything. V13 said, "I opened up diaper, asked R23 to turn and assisted R23. I think R23 has something was with her legs. I think she has injury or something. I turned her on the right side towards the window so her weight is on the right side. R23 always complained that she is in pain all time because of her injury. I don't know if she told me to be gentle. I cannot remember."

V13 said, "An unknown staff told me there was a complaint with the resident (R23) and they told me who it was. I understood that the lady (R23) was very fragile. She (Unknown Staff) explained and mentioned therapy staff. I cannot remember

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

what they told me." This surveyor asked V13 how many times she changed R23 before therapy? V13 said, "Only 1 time." After clarifying with V13 the question, asking if changed R23 before breakfast and who changed her before therapy. V13 said with upset voice, "I changed her, then R23 ate breakfast and changed her before therapy. That's the way she (R23) is, she also complained to me in the past." V13 was then very defensive about questions and got upset and verbally aggressive when it was mentioned that R23 has pain because of right leg / hip fracture. V13 said, "I don't like to be ask anymore. I don't want to be blame of something. The only thing missing for me to become a nurse is my license! I think I need to get an attorney because I don't want to be blamed for causing a fracture to R23." Explained to V13 that no one is blaming her about the fracture because R23 has that medical diagnosis since admission. V13 said, "I don't want to talk anymore! That's it! I will hang up!"

Review of R23's records are as follows:

R23's Care Plan has occasional bladder incontinence related to activity intolerance, impaired mobility. Physical limitations due to fracture of right greater trochanter. After full care plan was reviewed there was no plan of care for abuse and pain.

Facility Reported Incident investigation documentation (Initial and Final Report) does not include those therapists (V24, V26 and V27) as part of the investigation.

Abuse and Neglect Policy and Procedure dated 03/24/2022 as revised, in part reads:
To outline guidelines for the prevention of resident abuse and measures to be taken in the event any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 kind of resident abuse is suspected and identified. All residents have the right to be free from abuse and corporal punishment by anyone, including, but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies, family members, friends, or other individuals. For the purpose of this policy, resident abuse is defined as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish. ___ On 05/02/2023 at 10:29 AM, surveyor observed R24 and V39 (Son/POA for R24) sitting in R24's room. R24 stated that she is blind and that no one comes in and introduces themselves. V39 stated R24 has to go to the bathroom frequently and that a few CNA's come in and make comments like, "I'm not doing this or I'm not doing that" and have walked out of the room. V39 stated we made a complaint about one CNA in particular who was rude and reported that the CNA walked out on R24. V39 stated that the CNA was V30 (Certified Nursing Assistant). V39 stated, "I am not sure what was done about that situation, all I know is that V30 was moved from 2nd floor to the 3rd floor." Surveyor asked R24 how did V30's action make her feel. R24 stated she felt terrible and it made her cry. R24 stated she told V16 (LPN) about the incident. R24's diagnosis documents in part: Legal Blindness. R24's MDS Section C Cognitive Patterns (February 17th, 2023) documents in part: BIMS score is 15, which means she is cognitively intact. R24's care plan documents in part: R24 is	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8 incontinent of bowel and bladder due to reduced mobility secondary to neuromuscular weakness. R24 is legally blind. V28 stated she is also aware of the incident that took place on Monday April 17th 2023, about CNAs' being rude to R24. V28 stated V1 notified her and asked her if she could go talk to R24. V28 stated R24 stated that she was very upset. V28 stated R24 told her the CNA was upset that she had to take her to the bathroom. R24 stated, "Her attitude was nasty and she stated that she is not going to take care of me and walked out." When V28 asked R24 who the CNA was, R24 stated V30 (CNA). V28 asked R24 how she knew it was V30. R24 replied that she recognized her voice from the previous time V30 had worked with her (R24). V28 stated R24 told V28 that she was upset and that she had called her son to talk to V28. V28 stated, "I am sure these incidents happened and I am not sure if any in-services were done." V28 stated she would report this to nursing and to V1 and make sure that V30 (CNA) will not work with her (R24) again. --- R42's Facesheet documents in part: Medical diagnosis- need assistance with personal care. R42's care plan documents in part: R42 has an ADL Self Care Performance Deficit secondary to impaired mobility, decrease in ADLs, Physical Limitations: Balance problems, gait, strength, endurance. On 05/02/2023 at 12:55 PM, surveyor observed R42 laying on her bed in her room. R42 stated a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

staff member was very rude to her. R42 stated, "One time I had trouble with my bowel movements, and I was going frequently. A CNA came into my room, threw the diaper on my bed, didn't say anything and walked out. I am not sure who it was." R42 stated she told V16 (LPN). Surveyor asked R42 how she felt after the incident, R42 stated she mentally felt hurt and distressed.

On 05/03/2023 at 1:00 PM, V16 stated that R42 did tell him about a staff member being rude to her. V16 stated that he told the administrator, and then V28 (Director of Social Services) came to talk to her (R42). V16 stated that R24 also notified him about V30 being rude to her. V16 stated that he told V28 and V28 went to talk to R24.

On 05/04/2023 at 10:31 AM, V28 (Director of Social Services) stated when an abuse is suspected the expectation is myself or my co-worker notify the administrator and then we interview the person. We interview other residents, and then the nursing leadership departments will get statements from their staff. Usually, one of the nurse supervisors or V29 (Assistant Director of Nursing) will get the statements from the staff. Sometimes it does fall on V1 (administrator) to collect the statements if the nursing staff is unavailable. V1 is the abuse coordinator. If there is an allegation of staff members being rude to residents, the expectation is to do an official investigation. V28 stated, "I do all the documenting and questioning. If I am notified first, then I would tell V1 (Administrator). After the investigation is complete, we make a decision if the allegation of abuse is substantiated or not. V28 stated she was notified of staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10 members being rude to R42. V28 stated she talked with her (R42). The incident took place on March 21st, 2023. V28 stated V16 (LPN) notified her that a couple of CNAs' were rude to R42 and if ask she (V28) could talk with her (R42). V28 stated she notified V1 about the incident only after talking to R42. When V28 talked to R42, R42 stated the CNAs' threw the diaper on her bed and walked away. I did not interview anyone else about this incident. On 05/04/2023 at 10:50 AM, V2 (Director of Nursing) stated she is not aware of any abuse allegation that took place with R42 nor the incident that took place with R24. On 05/04/2023 at 10:55 AM, V1 (Administrator) stated she did not do a full, thorough investigation for these two abuse incidents. V1 stated that after speaking to V28, she didn't think the allegation was abuse so she didn't do a full abuse investigation. V1 stated the incident against R24 took place on April 17th, 2023. V1 stated that when she looked back at the schedule, V30 didn't even work the day of the alleged event, so didn't bother to investigate further. On 05/04/2023 at 11:00 AM, V5 (Executive Director) stated V1 didn't do a full abuse investigation but a soft investigation because the impression V1 received from V28 (Director of Social Services) was that there was no abuse. Facility's soft investigation for R24's mental abuse allegation dated April 17th, 2023, documents in part: V30 didn't work on April 15th, or 16th. Reviewed facility's nurse/CNA schedule for April 2023. V30 last worked April 8th, 2023.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11 Facility's abuse policy (3/24/22) documents in part: All residents have the right to be free from abuse and corporal punishment by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies, family members, friends or other individuals. Mental abuse is defined as but not limited to humiliation, harassment, threats of punishment, withholding of treatment or services. (A)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Sheltered Care Licensure	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.1710 e) 330.1710 f) 1) Section 330.1710 Resident Record Requirements e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy. f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that ongoing clinical assessments and the identification of changes in condition were reflected in the level of	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

care provided, in order to meet the resident's needs. This failure affected three (R1, R2, R3) out of ten residents reviewed for sheltered care services.

Findings include:

On 05/03/2023 at 10:33am, R1 observed approaching another resident's room while surveyor was inside with another resident. R1 observed with a pink cast on R1's left arm and ambulating via walker. Surveyor asked R1 if it was R1's room that R1 was entering. R1 stated that she doesn't know. Surveyor asked R1 what her room number was and R1 was unable to answer. R1 was redirected by resident whose room R1 was about to enter. R1 was then observed ambulating via walker into R1's room. Staff observed inside of R1's room assisting R1 with changing R1's incontinence-briefs.

R1 stated, "I normally never wet myself but if I do, then I change my own under-briefs. This is the first time they are helping me with changing my under-briefs." When asked what happened to R1's arm, R1 was not able to verbalize what happened to R1's arm. R1 stated, "I was doing something but I can't remember."

On 05/03/2023 at 10:11am, V32 Registered Nurse (RN) stated, "I have been working here for 3 years. The nurses work 12 hour shift from 7am-7pm. There are no nurses working on this unit (identified as 4th floor sheltered care/memory care) after 7pm. There is only 1 Certified Nursing Assistant (CNA) scheduled on this floor since the residents on this unit are largely independently functioning."

On 05/03/2023 at 10:35am, V32 stated, "R1 has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 a cast on R1's arm because R1 fell on 04/07/2023 and injured R1's left wrist. R1 now requires assistance with changing R1's incontinence briefs since R1's wrist injury." On 05/04/2023 at 9:09am, V31 (Admissions Coordinator) stated she has been working at the facility for 1.5 years and that the admission process is as follows: " First we receive a referral, give the family a tour of the facility, if possible, ask for clinical documentation, then nursing staff reviews the documentation, then there is the application process. The nursing staff usually assess the level of care and determines where the resident is placed. I don't have the criteria information in writing for the difference between sheltered care and skilled care. Sheltered care is similar to assisted living and independent living. The 2nd floor is a combination of sheltered care and skilled nursing. 2N is more independent residents and they need less assistance. 2W are for residents who are needing more care. The 3rd floor is skilled nursing. The 4th floor is also memory support and sheltered care and they need more assistance. If a resident is on hospice, then they can stay on the same unit. If a resident is not on hospice care, then we would meet with the family and discuss the need to increase the level of care to another unit." On 05/04/2023 at 10:04am, V2 (Director of Nursing/DON) stated, "When a resident is admitted to the facility, there is a basic assessment form that uses a point system to score the resident to determine the resident's level of care. Each resident does not have their own level of care form, we just use it to score the resident to then determine their unit placement. Family preference is taken into consideration when determining the resident's unit placement	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

but is not a deciding factor. We reevaluate the residents every week during our Medicare meeting and we also update the family of any changes. Sheltered care residents are more independent and tend to order their own meals, walk and perform their own Activities of Daily Living (ADL) care. If a resident needs skilled services, then they are not appropriate for the sheltered care unit they may need more help. Changes are made to a resident's unit assignment when a resident have a change of condition or the resident experience a significant decline. The skilled nursing unit side tend to have residents who require a total bath, feeding assistance, wound care, or have to be turned and reposition every 2 hours. A resident should be on the skilled nursing unit if they are not able to walk or toilet themselves, but we also ask the doctor for their opinion to determine placement for the residents. We have a nurse working on the 4th floor sheltered care unit for 12 hours during the day. On the night shift, there is 1 CNA and a night supervisor who is a Licensed Practical Nurse (LPN) and located on another floor of the facility. In the event of an emergency, then the CNA would call the supervisor right away."

On 05/04/2023 at 11:25am, a telephone interview with V10 (Medical Director) was conducted. V10 stated, "I round on the residents at the facility at least once a month. If a resident is admitted and assessed for a level of care, then that level of care remains and should be followed. Another assessment would be required when there is a change of condition or a new situation arise with the resident."

On 05/04/2023 at 1:28pm, V37 (Billing and Collection Specialist) stated, "If a resident is assessed for skilled nursing, then they would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

reside on the sheltered or memory care unit. Skilled nursing resident services can be billed to Medicaid. Anyone who requires skilled nursing should be located on the skilled nursing units. I am not sure who determines which resident goes to what unit but I think that the couple of residents who are on the 4th floor who are not sheltered care are exceptions made by either admissions or the administration team."

Per facility MDS dated 02/03/2023, R1 is alert and oriented to person with a Brief Interview for Mental Status (BIMS) of 9. R1 is supervision and one person assist with ADL care, occasionally incontinent of bladder and continent of bowel, and ambulates via walker.

R1's admission assessment dated 01/14/2020 documents R1's level of care as sheltered care. Document template dated 05/2020 and titled "Level of Care" was provided to surveyor by V2 on 05/04/2023 at approximately 10:15am. V2 verbalized that this document was used to determine the resident's level of care score in order to determine unit placement.

R1's care plan dated 04/07/2023 documents that R1 is care planned for risk for pressure ulcers, dentures, eyeglasses, GERD, impaired cognitive function, risk for falls, arthritis, anxiety, elopement risk, and ADL self-care deficit. R1's care plan documents that R1 fell on the following dates:
05/02/2022- fracture of right hand
09/22/2022- laceration to the head: 5 staples
12/02/2022- no injury
12/03/2022- no injury
12/14/2022- no injury
12/21/2022- no injury
04/07/2023- left wrist fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 R1's fall risk assessment dated 02/03/2023 documents that R1 is a high risk for falls with a fall risk score of 18 and multiple falls within the last 2-6 months. On 05/03/2023 at 10:13am, R2 observed with a red sticker outside on R2's door that read "TBL". R2 observed resting in bed with head of bed at 45 degrees. Geri chair observed at bedside and floormat next to R2's bed. An interview with V32 (RN) was conducted and V32 stated, "R2 is considered a TBL (total body lift) which means that she has to be moved and transferred via a Hoyer lift. R2 is not ambulatory and can only use her abdominal muscles to pull herself up to a sitting position. R2 has had a fall in the past and uses the Geri chair for ambulation. R2 requires incontinence care from the staff and was recently taken off of hospice care." Record review included progress notes, physician orders, care plan, MDS, face sheet, and POS. Per facility MDS dated 04/01/2023, R2 is alert and oriented to person and place with a BIMS of 2. R2 requires extensive assistance and total dependence with 1-2 person assist with ADL care. R2 is incontinent of bladder and bowel and does not ambulate via walking. R2's care plan dated 04/03/2023 documents that R2 is care planned for risk for pressure ulcers, risk for falls, risk for pain, incontinence, arthritis, need for 24-hour supervision and care from staff, dementia, and ADL self-care deficit. R2's admission assessment dated 03/28/2021 documents R2's level of care as Medicare skilled. On 05/03/2023 at 10:18am, R3 observed sitting	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

up in bed in a semi-fowler's position with breakfast meal on bedside table in front of R3. Oxygen concentrator at R3's bedside currently not in use.

Surveyor and V32 (RN) located inside of R3's room. R3 states that R3 walks on her own and is able to shower by herself. An interview was conducted with V32 at 10:18am, V32 stated "R3 is also considered a total body lift (TBL) and is non-ambulatory and needs assistance with ambulation and incontinence care. R3 verbalizes that she is able to perform tasks on her own, but R3 cannot perform her own ADL care without help from the staff."

Record review included progress notes, physician orders, care plan, MDS, face sheet, and POS. Per facility MDS dated 02/22/2023, R3 is alert and oriented to person and place with a BIMS of 6. R3 requires extensive assistance and one-person physical assist with ADL care. R3 is incontinent of bladder and bowel and ambulates via wheelchair. R3's care plan dated 02/22/2023 documents that R3 is care planned for risk for pressure ulcers, incontinence, impaired cognitive function, risk for falls, hospice care, and ADL self-care deficit.

R3's admission assessment dated 12/19/2020 documents R3's level of care as Medicare skilled. R3's Physician Order Sheet (POS) documents that R3 has an order for oxygen 2-5 liters via nasal cannula as needed for shortness of breath.

Facility Census dated 05/01/2023 documents that R1, R2, and R3 reside on the 4th floor of the facility (identified as the sheltered care/memory care unit).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 Facility document dated 05/2023, titled "Facility Assessment" documents in part "Our facility has a comprehensive process in place to assess resident needs and determine the care and services required. We utilize a comprehensive admission, readmission and required assessment process in which the interdisciplinary team identifies individualized resident care needs." (B)	S9999		