STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001168	A. BUILDING: _____ B. WING _____	C 06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF BRIDGEVIEW, THE	8100 SOUTH HARLEM AVENUE BRIDGEVIEW, IL 60455

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S 000	Initial Comments Complaint Investigation: 2395933/IL161075	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.3210t) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. ection 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: Based on observation, interview, and record review, the facility failed to ensure that 1 of 3 residents (R1) reviewed for abuse, was free from abuse from a staff member. This failure resulted in R1 suffering an abrasion to her face, sore ribs, and feeling angry and taken advantage of.	S9999		

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S9999	Continued From page 2 Findings include: On 6/27/2023 at 11:45 AM, V1 (Administrator/Abuse Coordinator) states she reviewed tapes of the incident that occurred on 6/18/2023, resident was in and out of her room making noise. Resident attempted to leave and went downstairs at about 4:00 AM then went to her room. At around 6:15 AM, R1 came down again and got through the front doors. V5 (CNA) came downstairs and grabbed the back of R1's wheelchair and pulled R1 backwards, and V1 believes resident knocked her own glasses off her face. On 6/27/23 at approximately 2:35 PM, while reviewing incident video with V1 (Administrator/Abuse Coordinator). V1 states there is no one at the reception desk at 6:00 AM in the morning. Observed at 6:15:43 AM, R1 comes into view propelling herself in a wheelchair and pushing a rollator walker and approaches the exit door. R1 pushing on the bell (which V1 states alerts the staff) several times and fidgets with the door. Eventually R1 pulls open the sliding glass exit door at 6:17:03 AM and goes through the door into the vestibule. The second exit door opens automatically and R1 goes out the door and is sitting at the entrance of the facility. Observed at 6:17:46 AM, V5 (CNA) comes into view and walks out of the doors and without any pause or hesitation, immediately grabs the resident's wheelchair and starts to pull her backwards towards the sliding glass doors. R1 starts swinging her hands backwards as if trying to remove or keep V5 from moving her. V5 uses left hand and is consistently trying to move R1's hand. V5 at one point tries to propel R1 forward	S9999		

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S9999	Continued From page 3	S9999		

and R1's feet stops the forward progress. V5 then turns R1 backwards and pulls R1 into the vestibule. About halfway into the vestibule, R1 stands up and V5 immediately grabs R1 by the back of her shirt and pulls R1 down and backward into the wheelchair. R1 falls back into the chair and R1 rocks and tilts to the left side a couple of times before stabilizing.

V5 then continues to pull the resident backwards in the wheelchair into the facility. V5 then sits in a chair in the lobby with R1 in front of her. R1 moves her upper body forward and V5 pulls her back by R1's shirt. R1 again starts to strike behind her. V5 then gets up and starts wheeling R1 backwards down the hallway. R1 starts resisting and swinging backwards. V5's left hand and arm is observed moving erratically with R1's and there is a lot of swinging and movement near the left of R1's face that is difficult to see on the video. R1 then tries to hold onto one of the side rails in what looks like an attempt to stop V5 from moving her. V5 pulls R1's hands away from the safety railings. V5 is holding onto R1's arms and at some point, during the scuffling, R1's glasses are knocked off.

Observed at 6:19:23 AM, V6 (RN) coming down the hallway. V6 is seen talking to resident for a short time and R1 is talking and pointing. R1 is not swinging at V6 or trying to hit her. There is no physical altercation between V6 and R1. R1 appears to then leave with V6 calmly and voluntarily.

On 6/27/23 at 2:47 PM, while still viewing the video tape of the incident surveyor asked V1 (Administrator) if she thought V5 did anything inappropriate in the video. V1 states she doesn't like the approach V5 took to go get R1. V1

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S9999	Continued From page 4 states, "She [V5] doesn't know how to handle aggressive resident's, which is apparent from this [video]." On 6/27/2023 at 11:02 AM, R1 states that V5 (CNA) worked every other day and is always nasty. R1 states that V5 was taunting her, and she went to go find the nurse to get medication. R1 states she didn't know why she was doing that, and she just ignored her. R1 states she couldn't find the nurse and she was done at this point. She took her stuff and walker. R1 states she went down to the first level with her stuff and went to open the door downstairs and the alarm went off. V5 states she tried to get up from the wheelchair to take her walker and leave. R1 states V5 (CNA) said "Sit Down", and the CNA pushed her down into the chair. R1 states she tried to get up again to leave and the 2nd time she shoved me back into the chair and my glasses fell. I tried to get up a 3rd time and she closed fist punched me in the left eye. R1 states they have cameras in the facility. R1 states V5 (CNA) smacked her with a closed fist. R1 states, "I certainly did not see that coming." R1 states she was wheeled to her room, and she called 911. On 6/29/2023 at 10:34 AM, R1 states, "It made me angry when V5 was pushing me back when I wanted to leave. She had no right to put her hands on me. I have 4 broken ribs and it got irritated when she pushed me, and it was painful. She smacked me in the face with a closed fist. I was in shock that she punched me. I didn't think they were supposed to do things like that." While crying R1 states "I was angry that V5 took advantage of my handicap, and I wasn't able to defend myself. I couldn't stand up and defend myself!"	S9999		

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S9999	Continued From page 5 On 6/28/23 at 1:59 PM, V5 states R1 and another resident were cursing, talking loud, and saying racist things. The first time R1 went to get on the elevator I attempted to stop her and she said, "leave me the F*** alone." V5 states she called V6 the supervisor because the nurse was not available. Later she was doing her rounds and V9 (nurse) called her and said that R1 had gotten out and can she go get R1. V5 states R1 was inside the 2 glass doors, and I attempted to push her inside and she stopped. When I first saw her, I just grabbed the back of the wheelchair she was sitting in. I told her you can't go out the doors. I grabbed the wheelchair turned it and she kept stopping it with her feet, so I turned it around and backed into the door. Surveyor asked, "At any point did the resident try to get out of the chair." V5 said, "No she was just fighting a lot. She was swinging her arms back to hit me because she didn't want me pushing the wheelchair." Surveyor asked, "At any point did you pull her back into the chair." V5 states, "No, I didn't pull her back into the chair. She was always in the chair." V5 states R1 was alert and oriented and she (V5) had worked with her before. V5 states, "Yes," at 6 am it was appropriate for her to pull R1 into the facility against her will. Surveyor asked, "do you think it is appropriate to pull someone down from behind into a wheelchair." V5 states, "No, of course not. They can hurt themselves." V5 states "I would think that is abuse if I saw someone do that." Surveyor asked "if it is appropriate to pull R1 back into the facility when she is fighting and saying she doesn't want to go in." There was a long pause and V5 said, "Ordinarily, no." Surveyor asked, "why was it okay to do it this time with R1." V5 states, "because of the time of day and no one	S9999		

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S9999	Continued From page 6	S9999		

was waiting for her."

On 6/27/2023 at 12:57 PM, V4 (Licensed Practical Nurse) states he remembers R1. V4 states, R1 was alert and oriented and cooperative.

On 6/27/23 V3 (CNA) states R1 was a nice lady. V3 states R1 was alert and oriented and could transfer by herself. V3 states R1 kept to herself and stayed in her room. V3 states R1 was never combative, and she never got any reports that she was.

On 6/28/2023 at 10:10 AM, V6 (RN) states R1 is completely alert and oriented. V6 states the first time V5 (CNA) called her because R1 had left the unit. V6 states she saw her downstairs. V6 states, R1 was saying she didn't want to be at the facility. V6 states she tried to calm her down and eventually got her to go back upstairs. V6 states she got a 2nd call, said the resident was trying to leave. V6 states when she got to the lobby, V5 was trying to get R1 back to the unit. V5 was wheeling her backwards and R1 was swinging and resisting by swinging her arms. V6 states, I intervened and told V5 to just go. V6 states she told R1 to calm down. She said she wanted to go. V6 states she told R1 leaving against medical advice (AMA) and R1 said she would sign anything because she wanted to go. I believe R1 is self-responsible for her care. She has the competence to sign the AMA form and leave if she wants. I believe that she has the right to leave, and we would just document that she refused to sign AMA if she didn't sign the form. V5 states, if she had seen R1 outside, the first thing she would do is talk to R1, tell her to stay calm, and redirect her to the facility. V6 states, "I wouldn't approach the situation with aggression

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S9999	Continued From page 7 so that it does not escalate." Police report dated 6/18/2023 and reported at 6:20 AM documents: Officer was told when he arrived that R1 was sent to the hospital. Officer interviewed resident in the Emergency Room. R1 told officer she tried to leave the facility and was stopped physically by her CNA. R1 stated she was struck in her left eye by a closed fist of the CNA. R1 advised the officer that her CNA also pushed her by the shoulder into a chair. Officer observed redness upon R1's upper left cheek near her eye. Nurse told officer that R1 tried to leave and was told she couldn't leave based on her mind and no means of transport or shelter and that R1 was restrained at this time and the process was started to have R1 involuntarily committed. Hospital records dated 6/18/23 documents R1 reported that the CNA at the facility pushed her down into a chair and after that, punched her in the face. Page 11 documents: Patient presents to the emergency room with reports of abuse at her nursing home. Patient is to be Alert and oriented times 3. No evidence of active psychiatric disease clouding her decision making. Emergency Department (ED) Notes: Patient states: I was hit in the left eye by a CNA at the facility she was living. The CNA kept pushing her down every time she tried to get up. V15 (nurse) from the facility stated they were petitioning the patient, psych evaluation, due to patient attempting to leave against medical advice and being combative with the staff members. R1's left eye was noted to be red with a small abrasion. R1's MDS (Minimum Data Set) dated June 13, 2023, documents R1's cognition to be intact.	S9999		

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S9999	Continued From page 8 R1's Abuse and Neglect Care Plans documents the following intervention: Approach in a friendly, calm manner; treat with dignity and respect. Dated 3/20/2023. The facility's Abuse Prevention Program policy dated 10-2022 documents the following. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. (B)	S9999		