STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005904	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE COUNTRY CLUB HILL	18200 SOUTH CICERO AVENUE COUNTRY CLUB HILLS, IL 60478

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S 000	Initial Comments Complaint Investigations: 2497050/IL177549 2497124/IL177658	S 000		
S9999	Final Observations Statement of Licensure Violatiuons: 300.610a) 300.1210b) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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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)

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect resident rights to be free from physical abuse by staff. This failure affected two (R1 and R2) of four residents reviewed for abuse and resulted in R1 sustaining swelling and redness to her left eye and being transferred to a local hospital to rule out orbital fracture and R2 sustained redness to his face after being slapped by a staff.

Findings include:

R1 is a 55-year-old female who has resided at the facility since 2020, past medical history includes, but not limited to: cerebral palsy, spastic hemiplegic cerebral palsy, paroxysmal atrial fibrillation, vascular dementia, essential primary hypertension, encounter for attention to colostomy, anemia, schizoaffective disorder, bipolar disorder, generalized anxiety disorder, hypotension, etc.

On 9/5/2024 at 10:25AM, R1, who just returned from the hospital was observed in her room, awake and alert and was being assisted with ADL (activities of daily living) care by V10 (restorative aide). R1 was asked why she went to the hospital, and she R1 stated, "the two CNA's (certified nursing assistant) hurt me, one was on the right side and was twisting my hand and

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fingers, the other was on the left side hitting me with the remote control." R1 tried to demonstrate what happened by twisting surveyor's fingers and used her bed remote control to demonstrate how the CNA hit her face. R1 was noted with some dark purplish bruising to her right hand, some redness to her left cheek under the left eye and a little swelling around the left eye.

Progress note dated 8/31/2024 at 9:32AM documented that R1 was noted with swelling and discoloration to her left eye, patient complained of some pain and pain meds were given. Attending physician who was on ground was notified, ordered for the resident to be sent out to a local hospital.

Physician progress note dated 8/31/2024 at 12:10PM states in part: patient seen and examined, patient is complaining of swelling and pain on the left eye patient stated that somebody had hit her. No fever or chills, patient states she cannot move her left eye, will send patient to the hospital for evaluation of possible orbital fracture.

Facility reported incident dated 8/31/2024 documented in part that R1 was noted with discoloration to her left eye, and she described the two staff that she alleged caused her the injury while providing her with ADL care.

Police report dated 8/31/2024 documented that police responded to the facility for a delayed battery report. In the report, R1 was named as the victim and V6 (CNA) and V7 (CNA) named as the suspects. According to the police report, R1 reported that one staff slapped her across the face and the other one twisted her right hand and fingers, resident was noted with discoloration and swelling to her face and bruising to her right

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hand.

Hospital record dated 8/31/2024 documented as chief complaint that R1 presented with an allegation of being hit in the face with a remote and staff twisting her fingers at the nursing home.

9/4/2024 at 1:22PM, V4 RN (registered nurse) stated that she came to work on 8/31/2024 and was making rounds around 7:15AM when she noticed R1's leg out of the bed, she asked another nurse to come and help her reposition resident. R1 reported that she was abused by two staff members (CNAs), but she does not know their names. V4 had not seen or heard R1 making such an allegation in the past. V4 confirmed that R1 was complaining of pain to her hands and left eye. V4 noticed some bruising and swelling to R1's left eye and bruising to her left hand that was purplish/blue in color.

9/4/2024 at 2:09PM, V8 MD (medical doctor) stated that he came to the facility to see R1 and noticed some swelling in her left eye and that the resident stated that 2 CNAs abused her and she was complaining of pain. V8 also noted small redness inside resident's eye and decided to send her to the hospital for further evaluation. V8 added that the redness and swelling also could result from an infection or abuse but he is not sure, he did not check resident's hands, he saw the resident before going on vacation and she did not have the redness. V8 added that R1 has never made any abuse allegation in the past, the redness and swelling was new and resulted from a recent incident.

9/4/2024 at 3:41PM, V2 DON (director of nursing) stated that she was called by a staff between 7:00 - 8:00AM and was notified that R1 said that she

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was hit by someone. V2 went to resident's room and noted some discoloration to her left eye.

9/4/2024 at 3:59PM, V1 (Administrator) stated that R1 has a behavior of throwing herself on the floor, removing her colostomy bag, etc. to get attention. Both CNAs denied hitting R1.

Review of medical records did not show any documentation of R1 ever accusing any staff of abuse before this incident.

R2 is an 87 year old resident with past medical history that includes: metabolic encephalopathy, acute kidney failure, unspecified injury of head, urinary tract infection, major depressive disorder severe with psychotic symptoms, hyperlipidemia, dysphasia oropharyngeal phase, alzheimer's disease, parkinson's disease, depression, anxiety disorder, etc.

On 9/3/2024 at 11:15AM, R2 was observed in his room, awake, alert, and oriented with some confusion. R2 recalled being slapped on his face by someone but does not recall exactly what happened.

Progress note dated 8/9/2024 documented that resident was noted with redness to the side of his face, resident denied pain, MD and family notified.

Facility reported incident dated 8/9/2024 documented that the administrator was notified that R2, and a nurse practitioner (V11) were involved in a physical altercation, body assessment completed, resident noted with redness to right side of face, no complaints of pain, MD, family, and police were notified, police report completed. The report concluded that R2

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was abused by V11 who was reported to her employer group and is no longer employed at the facility.

Police report stated that police responded to the facility for a delayed battery. R2 was listed as the victim and V11 (Nurse Practitioner) as the offender. The same report documented that V11 admitted being at fault, stating that she was suffering from multiple problems at the time. Review of the training provided to V11 by the facility did not list any training on abuse. V11 completed training on infection control, HIPAA (health insurance portability and accountability act, antimicrobial stewardship, do not abbreviate, etc.

9/4/2024 at 12:54PM, V3 LPN (licensed practical nurse) stated that she was in the building the day R2 had an incident with a staff, she just got out of the elevator and saw R2 agitated, the nurse practitioner (V11) was trying to calm R2 down, but he became more agitated. Staff moved resident to another part of the nursing station, R2 started using vulgar terms stating V11 struck him. Resident was noted with some redness to the right side of his face, he did not require any medical treatment and denied any pain.

9/4/2024 at 3:59PM, V1 (Administrator) stated that she completed the abuse investigation for R1 and R2. For R2, the conclusion was that V11 became aggressive with the resident and was escorted out of the building immediately. The facility does not provide abuse training to non-staff, V11 is not a staff of the facility but part of a provider group, the facility is not responsible for training her on abuse.

9/4/2024 at 3:41PM, V2 (DON) state that she

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S9999	Continued From page 6 spoke to V11 (NP) who admitted hitting the resident and was complaining of being overwhelmed. R2 is not aggressive, he is alert and oriented with some confusion. Facility abuse prevention and reporting policy revised 1/22/2019 states in guidelines that the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Under orientation and training, the document states in part that during the orientation of new employees, the facility will cover at least the following: sensitivity to resident's rights and resident's needs, what constitutes abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. (B)	S9999		