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 _____	C 09/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE PALOS HEIGHTS	12550 SOUTH RIDGELAND AVENUE PALOS HEIGHTS, IL 60463

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S 000	Initial Comments Complaint Survey: 2497010/IL177506	S 000		
S9999	Final Observations Statement of Licensure Violations 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 care needs of the resident.	S9999		

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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 Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to prevent one resident (R1) from mental abuse caused by a staff member and failed to ensure the staff member had limited access to R1. This failure applied to one (R1) of three residents reviewed for abuse and resulted in R1 feeling "on guard, untrusting and unsafe" while living in the facility.

Findings include:

R1 is a 68 year old female who admitted to the facility 2/16/24. R1 has diagnoses that include Conversion disorder (functional neurological system disorder) and Generalized Anxiety Disorder for which she is receiving treatment in the facility. R1 is cognitively intact and uses a wheelchair for mobility according to the minimum data assessment dated 8/25/24.

On 8/21/24 at 8:34PM, R1 was observed resting in bed, alert and coherent. R1 was interviewed and expressed an incident with a staff member (V3) that occurred a few weeks ago. R1 said that one evening, she went to the kitchen because she was hungry and asked V3 Dietary Aid for some food. V3 refused to give any food or snacks and called R1 a "beggar". R1 said that she believed V3 was upset with her because she offered V3 soda pops from her personal

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refrigerator, but later stopped.

R1 said, when she was refused food and V3 called her a name, she reported it to V1 administrator and V4 Dietary Manager via a letter. After the letter was received, the administrator had a meeting with R1, R1's family member and V4 Dietary Manager to discuss the incident. The end result led to V3's termination. R1 continued and said that about three weeks later, V1 came to R1's room insisting that R1 give V3 another chance because V3 was remorseful, and she should forgive V3 "as [R1 is] a good Christian woman". R1 began crying as she continued. R1 said V1 then brought V3 into her room to make V3 apologize to R1, however he just said a general apology, not anything that he did wrong. V1 rehired V3 to be a CNA (Certified Nursing Assistant). R1 said, I was okay thinking that I wouldn't see V3 much because V3 was working in the kitchen, but now as a CNA, I see V3 all over and V3 even comes in my room to drop off the meals and take the tray. R1 said "I feel so guarded around V3 because I don't trust V3. There have even been times that V3 has backed me up into a wall away from the cameras where no one could see and say ugly things to me". R1 continued to cry and said "I thought I did all the things right by reporting and I don't feel safe and secure when V3 is around. I am also concerned if what he is doing to me, he can be doing to others that can't defend themselves."

On 9/21/24 at 1:10pm V4 Dietary Manager said they received a letter from R1 that said that while working as a dietary aid, V3 was coming to her room drinking her personal drinks and watching television. V4 said 'there is no reason for any dietary aid to be going into a resident's room. When R1 told V3 she didn't want him to come

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into her room anymore V3 refused R1 snacks such as cereal and sandwiches. These things are allowed to be given when the kitchen is open by any kitchen staff.' After V4 received the letter, Guest Services Manager, the Administrator and V4 had a meeting with R1 and R1's family member. After the meeting, V4 said that V1 Administrator initiated an investigation into the issue and V3 was let go by Human Resources a day or two after. V4 found out V3 was terminated when V4 was told to remove V3 from the schedule.

On 9/21/24 at 1:23pm V5 Human Resources Director said that V5 was aware of an incident with R1 who stated that V3 called her a beggar. I spoke with V1, who followed up with V3 and I was told to terminate V3 for discourteous behavior which is based off the handbook and facility policies.

Employee Disciplinary Report reviewed for V3 dates the incident 9/2/24 with facts: "Employee displayed improper conduct and discourteous behavior with patient which has resulted in termination." The report was dated 9/5/24 by V5.

V3 was interviewed via phone on 9/19/24 and 9/21/24. During both interviews, V3 was evasive, omissive and unprofessional. During the interview on 9/19/24 at 10:16pm V3 said that V3 was "irritated" about being questioned by this Surveyor. When V3 was asked about any incident that occurred involving R1 and V3, V3 said he was told about it by an unknown staff member, and that there was no allegation brought against him. V3 also said that he had never been suspended or terminated.

On 9/21/24 at 4:05pm, V3 said that there was a

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day that R1 came to the kitchen to ask for food, but the staff were about to leave and V3 told R1 the kitchen was closed. V3 said R1 always come to the kitchen asking for food, and V3 didn't give her any when she asked. V3 said V1 investigated an allegation against him but V3 didn't take the accusation seriously. Then V3 said "I got fired for some b*****t." V3 said V1 Administrator asked V3 to come back as a CNA and was asked to apologize to R1. V3 said, he went to R1's room with V1 but said, "I didn't apologize, I just said I'm sorry".

On 9/21/24 at 2:45pm V1 Administrator said V1 was unaware that R1 was emotionally upset that V3 became a CNA and is giving direct care in the facility because V1 believed that after V3 issued an apology, R1 had forgiven V3. V1 said V3 should not be going into R1's room or giving care to R1, however it's possible that R1 would see V3 working elsewhere in the facility.

Concern form dated 9/2/24 taken by V1 Administrator stated, "Resident stated a dietary aide went into her room and took a beverage." Corrective actions taken: "Writer interview the dietary aide (V3) Dietary aide stated he removed the dietary tray after mealtime. Offer to replace beverage declined."

Abuse Prevention and Reporting policy revised 4/22 states in part; "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain

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S9999	Continued From page 5 or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 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 abuse policy was acknowledged and electronically signed by V3 on 8/27/24 at 4:10PM. (B)	S9999		