STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments Complaint Investigation 2496008/IL176186	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 interviews and records reviewed the facility failed to follow their abuse policy, failed to treat a resident with dignity and respect to prevent unauthorized photos of a resident restrained to a wheelchair in the hallway. This affected one of three residents R5 reviewed for mental abuse. This failure resulted in R5 having unauthorized

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photos taken of him restrained to a wheelchair. Using the reasonable person concept, it is reasonable to conclude that R5 felt cold, uncomfortable, and dehumanized when he was sitting in a wheelchair, in the hallway, with a sheet, no shoes, no socks.

Findings include:

On 8/29/24 at 11:21AM, V19 Certified Nursing Assistant (CNA) said, on 7/26/24 I saw R5 had a gait belt around him. V19 said I was assigned to be R5's one to one, monitoring him. V19 said I talked to V11, LPN, and V5, DON, and the scheduler. V19 said I told V5 about the gait belt around R5 before she left like at 4:30PM. V19 said they said if you don't want to watch the patient, then go home. V19 said I left the floor and then I came back up to the floor around 6:00PM or 7:00PM and R5 had the sheet around him. V19 said I got fired because of this. V19 said I saw R5 with the sheet tied with two knots around his stomach and he was sitting on a regular wheelchair, he also had the gait belt on. V19 said I documented it, V19 provided pictures to IDPH from his personal phone.

On 8/29/23 an image of identified resident R5 obtained. Image is of a male, with disheveled, long, black hair, and long facial hair. R5 sitting in a room, in a wheelchair, no socks or shoes, in a hospital issued gown, with a face mask on, below his chin. A second image of a male, dark skinned, sitting in a wheelchair, leaning forward, back exposed, no hospital gown is seen in the picture. Image matches with the identified hallway of the facility hallway, outside of the elevator to the left, in front of the dining room door, below sprinkler device. R5 sitting across from nurses' station

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desk with the back of the computer monitor. The floor pattern and wallpaper match to the facility décor. No face for the resident is visible and his feet are exposed, no shoes or socks. A blue scrub pant is visible in the lower corner of the image. A camera is observed in the vicinity directly in the line of sight where the resident in the picture is sitting.

R5 is 43 years old with diagnosis including, but not limited to Convulsions, Alcohol Abuse with Alcohol Induced Anxiety Disorder, Depressive Episodes, Schizoaffective Disorder, Dementia, Acute Cystitis, and Bacterial Pneumonia. R5 was admitted to the facility on 7/26/24 around 2:00PM - 2:30PM (per DON). At 6:02PM R5 was ordered a psychiatric transfer and transferred to the hospital on 7/27/24 at 12:25AM. R5 was admitted to the hospital.

On 9/10/24 at 9:46AM, V24 CNA said, on 7/26/24 around 5:00PM - 5:30PM, I was at home when V19 called me, he said they stuck him with a one-to-one monitor. V24 said, V19 said they were restraining the resident. V24 said, V19 was going to document by taking pictures. V24 said, I don't think V19 took pictures of R5's face, just the restraint. V24 said, I didn't report to anyone because I felt V19 had it under control and I didn't see it because I wasn't in the facility.

On 9/10/24 at 10:40AM, V18 Scheduler said, I heard V19 on the phone when I was walking in the hallway, after dinner between 5:15-5:30. V18 said, I heard V19 telling someone this resident he doesn't sit down, he is getting on my nerves. V18 said, I don't know who V19 was talking to. V18 said, I asked V19 if he was taking pictures and he said no he was not. V18 said, I told V5 I heard V19 say "I'm going to take pictures and send

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them." V19 said, V24 mentioned V19 told her he was going to send the pictures. V18 said, I told V19 you can't take pictures. V18 said, I didn't see V19 take pictures. The surveyor asked V18 do you have to see abuse happen to report it? V18 said no. V18 said, I felt I needed to call V5 to see if V19 needed to be sent home, because he was on the phone. V18 said, V19 stayed with R5 until the end of his shift. V18 said, staff are not allowed to take pictures of the residents because it is a HIPPA (Health Insurance Portability and Accountability Act) violation. V18 said, staff are not supposed to be on the phone while on duty with a resident. V18 said, staff are not to be on the phone while assigned one to one monitoring with residents.

On 8/30/24 at 12:29PM V5 Director of Nursing said, V19 was terminated for being on his cell phone, twice. V5 said, on 7/26/24 I told him to get off the phone when I saw him. V5 said, another staff observed V19 on the cell phone and heard V19 talking about R5 and how bad R5 was and R5 did not need to be here. V5 said, that same night V19 was mad and said he was leaving, he was upset about having to do the one to one. V5 said, when I spoke to V18 by phone, it may have been 9:00PM or 10:00PM. V5 said, V19 did not finish his shift, we got someone else to monitor R5. V5 said, taking resident pictures is a HIPPA violation. V15 said, I told V18 to take V19 off the schedule until I speak with him on Monday.

On 9/3/24 at 3:20PM, V5 said, V18 Scheduler called me while I was at home and said when she walked in R5's room and saw V19 on the phone. V5 said, V18 reported V19 was on the phone talking to someone about how bad R5 is and something about pictures. V5 said, V18 said she asked V19 if he was taking pictures. V5 said, V19

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was the only CNA assigned to the R5. V5 said, after the surveyor spoke with me (on 8/30/24) I spoke with my staff and V24 said V19 called me and said he was going to take pictures of the resident. V5 said, V24 said she didn't report it because it didn't involve me, and she didn't want to get involved. V5 said, V18 and V24 should have both reported V19 on 7/26/24.

On 9/10/24 at 12:07PM, V25 Administrator said, V19 probably should not have completed the shift on 7/26/24. V25 said, V19 talking about R5 on the phone violates policy. V25 said, if I had been there, V19 would not have been allowed to return to the floor after walking out. V19 said, I did not know anything occurred with R5 until V5 spoke with me after she spoke with the surveyor.

V19 employee file notes his hire date is 7/10/24. Review of V19's employee file conducted. V19's HIPPA Quiz dated 7/10/24 has no responses for the questions. On 7/10/24 V19 signed I acknowledge that I have received and read the facilities abuse prevention program policy and procedure. I have received and read the social media policy. I understand the requirements of the social media policy represents the standards and policies of the facility.

The facility provided two Personnel Change Forms for V19, both dated 7/29/24. One notes termination is voluntary "Employee left on his own accord. Last day worked 7/29/24." The second form notes termination is Involuntary "violation of facility policy." No last day worked is noted.

IDPH received three pictures of R5 on 8/29/24 at 11:49AM. The last time V19 worked with R5 was on 7/26/24. R5 retained the pictures in his phone for 34 days.

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S9999	Continued From page 6 The facility abuse prevention program policy and procedure dated 1/2019 states during orientation of new employees the facility will cover at least the following topics prohibitions against taking, using, keeping, or distributing photographs, recordings of residents or a resident's personal space, as described in section Ivy below. The facility defined mental abuse includes taking or using photographs or recordings in any manner that would demean or humiliate the resident. This includes taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media networks. (B)	S9999		