STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008403	A. BUILDING: _____ B. WING _____	09/27/2024

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SCOTTISH HOME, THE	2800 DES PLAINES AVENUE RIVERSIDE, IL 60546

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S 000	Initial Comments Complaint Investigation: 2496779/IL177169	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 300.3240b) 300.3240c) 300.3240g) 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 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department	S9999		

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and to the facility administrator. (Section 3-610(a) 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)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These Regulations are not met as evidenced by:

Based on interviews and record reviews the facility failed to follow its abuse prevention policy to protect a resident from an incident of staff to resident abuse. This affected one of three R1 reviewed for abuse. This failure resulted in V4 (certified nurse aide) hit and/or pushed R1 in the face while providing care to R1. R1 sustained redness and swelling to R1's left side of face and blood in the corner of left eye.

Findings include:

On 9/25/24 at 11:00 AM, V2 DON (director of nursing) stated that the incident involving R1, and V4 CNA (certified nurse aide) occurred about 5:45 PM on 4/3/24. V2 stated that V15 (nurse) called her to inform her of the incident. V2 stated that she spoke with V4 via phone; V4 stated that while V4 was assisting R1 with transfer from wheelchair to bed, R1 grabbed V4's private area. V2 stated that initially V4 informed her that he pushed R1's hand away then stated he pushed R1's face away. V2 stated that V2 did not come to the facility that evening after incident to ensure

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all of the residents on that nursing unit felt safe. V2 stated that incident was not witnessed by any other residents or staff members. V2 stated that she called V1 (administrator) to inform of incident. V2 stated that V1 informed her that V1 would report the allegation of abuse and handle the investigation. V2 stated that V2 believes V15 notified V16 (attending physician) and R1's family of the incident; it would be documented in the nurse's notes or incident report. V2 stated that V4 was removed from the building. V2 stated that R1 was checked on frequently that night; R1 did not have any other needs that night. V2 stated that V2 did not assess R1 after incident. V2 stated that V2 did not speak with R1's family regarding allegation of abuse as the family did not request to speak with her.

On 9/25/24 at 1:12 PM, V1 (administrator) stated that V2 DON notified her on 4/3/24 of the incident involving R1 and V4. V1 stated that V1 did not come in, V1 had staff inform V4 to immediately leave building. V1 stated that V1 made a follow-up call to ensure V4 left facility. V1 stated that V4 informed V1 that in the middle of transferring R1 from wheelchair to bed R1 grabbed him and V4 hit R1. V1 denied being informed that V4 hit R1 in the face during initial phone call with V2. V1 stated that when V1 called facility second time, V1 was informed that R1 had redness on his face. V1 stated that on 4/4/24, V4 was terminated for hitting R1's hand. V1 stated that when R1 was interviewed, R1 stated that V4 hit him in the face. V1 stated that V16 (attending physician) came in the following day to assess R1. V1 stated that she did not know what the nurses were talking about because V1 did not observe any redness to R1's left eye when V1 saw R1 on 4/4/24. V1 stated that V1 faxed an allegation of abuse report to the

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State Surveying Agency but did not save the faxed document to confirm a report was sent and the date and time.

R1's medical record notes V16 did not conduct a face-to-face visit with R1 until 4/23/24.

R1's medical record, dated 4/5/24 at 10:28 PM, V15 noted R1's left eye with a slightly pinkish spot in the corner of inside the eye.

R1's medical record, dated 4/6/24 at 7:09 AM, the nurse noted R1's left eye slightly reddened.

R1's medical record, dated 4/6/24 at 2:28 PM, V15 noted no swelling, slightly reddened spot in the corner of left eye. At 11:06 PM, V15 noted R1's eye remains with slightly reddened spot to inside corner of eye.

On 9/25/24 at 3:30 PM, V15 (nurse) stated that V15 worked on R1's nursing unit on the evening shift on 4/3/24. V15 stated that after dinner, V15 was checking on R1. V15 stated that V15 was about to check R1's blood pressure and observed R1's left eye was pink. V15 stated that V15 asked R1 what happened, R1 responded that guy hit me as V4 CNA (certified nurse aide) was entering R1's room V15 stated that V15 asked V4 to leave and shut the door. V15 stated that V15 assessed R1 for any further injuries and pain. V15 stated that V4 was at the nurses' station. V15 stated that V15 asked V4 what happened, V4 responded R1 tried to grab V4's private area and V4 pushed R1's hand away. V4 denied hitting R1. V15 stated that V4 also stated if R1 does it again V4 was going to hit R1. V15 stated that V15 informed V4 that he is not supposed to do that. V15 stated that V15 called V2 DON (director of nursing) to inform V2 of what happened. V15

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stated that V2 wanted to speak with V4 so she handed him the phone. V15 stated that V4 repeated that he was going to hit R1. V15 stated that V4 was instructed to leave facility, staff watched to make sure V4 left. V15 stated that she doesn't recall if R1 had any redness, swelling, or blood in his left eye. V15 stated that V15 was present in the dining room during meal service and did not observe any redness or swelling to R1's face, or blood in R1's left eye. V15 stated that the dining room is well lit. V15 stated that R1's room is dimly lit and V15 observed R1's left eye looked like a blood vessel burst. When questioned if V4 came to her to report this incident, V15 responded no he did not tell her, R1 did. V15 stated that V15 believes she called R1's family on 4/3. V15 stated that she believes she told R1's family member there was redness on corner of R1's left eye, swelling, but denied informing family of allegation of abuse involving R1 and V4. V15 stated that she texted or called V16 (attending physician) but does not remember. V15 stated that the nurse documents details of incident-on-incident report or progress notes.

R1's medical record, dated 4/3/24, late entry, V15 noted R1 noted with redness inside the corner of left eye. R1 had no complaints of pain. R1's POA (power of attorney/family member) and V16 (attending physician) were made aware. V2 DON was made aware of incident and R1's condition.

There is no documentation found noting V15 notified R1's family member or V16 of the allegation of physical abuse involving V4 and R1.

The facility's incident report, dated 4/3/24, notes injuries: swelling to R1's face. Summary of incident: R1 was assessed by nursing and the

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nurse saw redness to the R1's left side of the face and that his eye, looked like blood vessel had burst. There was no other injury on R1. Investigation initiated. V2 received a call at approximately 5:45 PM, from V15, nurse on duty regarding a situation with V4 CNA and R1. V15 reported that R1 had grabbed the V4's private area during care. V4 reported to the nurse that V4 hit the R1's hand away. V4 also told V15 that if R1 does it again, V4 would hit him. V2 spoke with V4 who told V2 he was putting R1 to bed when R1 grabbed his "b***". V4 stated he was startled and out of reflex, pushed R1's hand away from him. V4 stated, "If R1 disrespects me again, I will hit him." V15 came back on the phone and said she went to see R1 and noted a reddened area on his eye, like a blood vessel had burst. The area was also reddened and appeared swollen. V15 stated R1 told her V4 hit him. V15 had given R1 medications earlier and had not noted any of this on his face. V2 spoke to V4 again, V2 asked V4 if he touched R1's face. V4 then said he pushed R1's face away. In the previous conversation, V4 said he pushed R1's hand away, not his face. V2 verified this statement with V4, and he again said he pushed R1's face away. V4 was terminated for physical abuse toward a resident.

This facility's abuse prevention policy, dated March 2022, notes administration will protect residents from abuse by anyone including, but not limited to, facility staff. Require staff training/orientation programs that include such topics as abuse prevention and identification and reporting of abuse. Identify and assess all possible incidents of abuse. Investigate and report allegations of abuse within required timelines.

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