STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005896	A. BUILDING: _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD CARE AND REHAB	5905 WEST WASHINGTON CHICAGO, IL 60644

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S 000	Initial Comments Complaint Investigation 23810506/IL167903 Facility Reported Incident of November 15, 2023/IL167672	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240b) 300.3240c) 300.3240e) 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. 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	S9999		

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S9999	Continued From page 1 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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 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) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the	S9999		

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S9999	Continued From page 2 perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep R6 free from abuse. This failure resulted in R6 being sprayed in the face with a chemical agent by a staff member (V26). R6 experienced eye irritation and pain which required irrigation at the emergency department. The facility further failed to keep V26 away from R6 after the incident by allowing V26 to continue to work with R6 and allowed V26 to remain on the same unit. Findings include: R6's face sheet documents in part medical diagnoses of psychosis, restlessness, and agitation. R6's comprehensive care plan does not contain a focus for R6's risk for abuse. Facility's final reportable to the Illinois Department of Public Health reads: an incident occurred between R6 and V26 (former Restorative Aide) on 11/15/2023. It documents in part: "Based on the known fact's resident appeared aggressive towards staff. Staff was fearful of resident and sprayed pepper spray at the resident and not on the resident." Surveyor reviewed the written witness statements and interviewed staff	S9999		

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S9999	Continued From page 3 regarding the incident. During interview regarding 11/15/2023 incident on 1/2/2024 at 12:19 PM, V18 (Nurse) stated, "There was something in the air when I got to the floor. I started coughing because it was something in the air. It was clear. Not cloudy or hazy or smoky but it made my eyes burn and caused me to cough that I had to turn right around. I couldn't respond properly to the code." V18's written witness statement dated 11/15/2023 documents in part that V18 could not properly respond to the code because V18 "started coughing bad" and "eyes were burning." On 1/2/2024 at 1:46 PM, V20 (Certified Nurse Aide) stated around 7:20 AM on 11/15/23, R6 was at the desk asking V39 (Nurse) about coffee and breakfast. V39 told R6 that breakfast will be up shortly and directed R6 back to the bedroom. The elevator opened and V26 (former Restorative Aide) was there. V26 told R6 to go to the bedroom. R6 stated [R6] did not want to go back to the bedroom and started yelling. V20 stated, "[R6] started coming towards [V26] a little aggressive so [V26] sprayed [R6] with something towards [R6's] face." R6 grabbed R6's head with R6's hands and put R6's head down. V20 stated V26 later took R6 to the bedroom. On 1/3/2024 at 2:13 PM, V35 (Nurse) stated, "I got off the elevator that day and it was something in the air that caused my eyes and nose running. I had to go someplace to get some air. I was coughing and had a headache for two days. I never experienced it before. I didn't know what it was. I had to drink cold water to get me through that day. I had to flush my eyes out and I wear glasses. Never felt that way while at work." V35 written witness statement dated 11/15/2023	S9999		

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documents in part: "When I came off the floor, something was in the air. My eyes were running. I started coughing and throwing up."

V13's (Nurse) written witness statement dated 11/15/2023 documents in part: "Elevator opened smell of pepper spray. I couldn't get off the elevator because the smell was so strong."

On 1/3/2024 at 2:27 PM, V24 (Psychiatric Rehabilitative Services Director) stated, "If a resident is agitated and aggressive towards someone, you try to separate them. Try to get them to calm them down by talking to them calmly. Ask what's going on and see what brought them to that level of agitation. We have to see what we can do to help them." When asked about R6's incident, V24 stated "they should have calmed [R6] down and talked to [R6] calmly and not be aggressive with it. You don't spray. No spraying. If it was that bad, you always call for help. Call for more assistance. If [R6] was escalating bad and showing more agitation, I'd call for help and step back and see what they can do. You're not supposed to have something on you in here to spray. I will walk away and get more assistance and let them know how [R6] is reacting. Find my exit and let them know this is what's going on so we can get more people to help."

On 1/4/2024 at 8:46 AM, V34 (Certified Nurse Aide) stated, "Me and [V18], the nurse, came out the stairwell and before I even reached the nurses' station, I had to turn around. I probably only got half-way through the hallway because the smell was so strong. It smelled like pepper spray. I had to turn around. It was affecting my eyes and getting into my nose. I just remember [R6] standing there by the nurses' station rubbing

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[R6's] eyes." V34's written witness statement dated 11/15/2023 documents in part that when V34 arrived on scene, "it smelled like bear spray." V34 had to turn around because V34's eyes were burning.

During interviews on 1/4/2024 at 9:22 AM and 11:35 AM, V26 stated R6 came towards V26 aggressively but [V26] did not spray anything at R6. V26 stated someone was spraying an air freshener in the hall. V26 stated afterwards that V26 brought R6 coffee and breakfast. V26 stated [V26] did not leave the facility until around 9:30 AM on 11/15/23. V26 acknowledged the facility provided an in-service about how to handle residents with behaviors at the beginning of the year but felt it wasn't specific to psychiatric behaviors or offered frequently enough throughout the year.

On 1/4/2024 at 11:58 AM, V37 (Director of Nursing at the time of the incident) stated staff are not to carry pepper spray or anything that is caustic or that's an eye irritant while working with residents. V37 stated if a resident is displaying aggressive behaviors, the "first line is to separate the individuals and try to talk and see what's going on or find root cause."

On 1/5/2024 at 12:08 PM, V42 (R6's Physician) stated, "Staff should not be using pepper spray in the facility. They shouldn't be carrying it. The purpose of pepper spray is to keep a person away from you. If it is sprayed and it goes into your eyes, it will have irritating effects because it is a chemical. You have to wash out your eyes."

On 1/9/2024 at 9:24 AM, V1 (Administrator/Vice President of Quality Assurance) stated a substance got into R6's eyes and the resident

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was sent to the emergency room for evaluation. V1 stated when facility reviewed the surveillance video of the incident, it was not an air freshener. V1 stated it was clear what the employee had on hand in the video.

On 1/9/2024 at 11:57 AM, V47 (Manager on Duty at time of incident) stated when [V47] arrived at the unit, R6 was frustrated, loud and upset. V47 stated, "I saw orange on him like orange pepper spray." V47 stated R6's face and eyes were red.

On 1/9/2024 at 10:02 AM, surveyor reviewed facility's surveillance footage of the incident with V3 (Director of Nursing), V25 (Assistant Administrator-in training), and V45 (Human Resources). No audio was with the footage. First review was of the fourth floor nurses' station camera angle which showed, on 11/15/2023 at 7:26:52 AM, V20 (Certified Nurse Aide) and V39 (Day Nurse) were at the nurses' station. Elevators are in front of the nurses' station. R6 came out of the bedroom and pressed the elevator button at 7:27:02 AM. R6 remained standing in front of the elevator door with R6's back turned to V20 and V39 waiting. No observation of physical aggression from R6 observed. At 7:30:50 AM, V7 (Wound Tech) emerged from the big elevator and went to grab the wound cart. There is a hand seen out of the elevator stopping R6 from getting on. At 7:31:04 AM, V7 brought the wound cart into the big elevator and V26 (former Restorative Aide) stepped left out of the elevator. At 7:31:10 AM, V26 is west of the elevator (if facing the elevator, V26 is on the right side) motioning in front of R6 and pointing towards east hallway - R6's room. R6 is facing V26.

During video footage review surveyor does not observe R6 to be puffing chest, running, or

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swinging arms. At 7:31:11 AM, V26 holds a small, black, cylindrical item with a silver split key ring with right hand. At 7:31:15 AM, V26 raises up the black cylindrical item with right hand as the left hand starts messing with it. V26 steps out of frame. At 7:31:29 AM, R6 remains facing west where V26 exited the frame. V5 (Anonymous Staff) is facing R6 standing to R6's right front. V39 came out of the nurses' station and grabbed gloves from the top of one of the medications carts. V20 is standing behind V39. V20 and V39 are facing R6. R6 takes a step, and a dark orange/almost brown substance shoots linear into frame and hits directly at R6's face. R6 raises left hand up over face. R6 stumbles back towards the nurses' station and hits the medication carts with right side at 7:31:34 AM. Staff start to disperse away from the scene. V20 (Certified Nurse Aide) has a hand over nose and mouth. V46 (Maintenance) uses blue shirt to cover nose and mouth. V39 (Nurse) is covering mouth. R6 remains by the medication carts holding head. At 7:32:20 AM, V5 (Anonymous Staff) is waving a white item to swat the air. At 7:32:40 AM, V26 (former Restorative Aide) passes R6 and heads to the dining room which is behind the nurses' station. At 7:33:40 AM, R6 remains near the medication carts. No staff has approached R6. R6 is bent over with head down. R6 grabs [R6's] face with the left hand. At 7:34:00 AM, multiple staff come out of the big elevator including V7 (Wound Tech), V21 (Certified Nurse Aide), V27 (Nurse), and V35 (Nurse). V27 can be seen bending at the hip, leaning forward, and coughing. At 7:34:18 AM, V26 is walking around R6 who remains near medication carts. V26 gets on the elevator at 7:34:22 AM. R6 remains in place while switching from standing to bending at the hip and leaning forward. At 7:36:23 AM, as R6 is hunched over, two large, liquid/fluid drops

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come from R6's face which appears to be saliva/spit. At 7:37:15 AM, V26 emerges from the elevator and returns to the unit. At 7:37:36 AM, R6 leaves the nurses' station unassisted to return to the bedroom.

During video footage review surveyor does not observe any staff come near R6 to assess or assist R6 in rinsing eyes or face out. At 7:38:15 AM, V47 (Manager on Duty) is seen standing by R6's room talking to someone (person can't be seen from camera angle). V26 remains on the unit and is seen at the nurses' station at 7:38:50 AM. At 7:41:09 AM, V26 has a white spray bottle and sprays repeatedly in the air. V26 does this multiple times throughout the unit including a few times in front of R6's room. At 7:46:38 AM, V26 went into R6's room. At 7:47:02 AM, V26 leaves R6's room, then went back in at 7:47:06 AM, and back out at 7:47:15 AM. At 7:47:35 AM, staff bring out coffee and breakfast carts from the big elevator. V26 grabbed a mug and pours a liquid into it. At 7:47:54 AM, V26 went into R6's room with white spray bottle in left hand and mug in right hand. At 7:48:09 AM, V26 leaves R6's room with the white spray bottle in right hand. V26 continues to walk around and spray the hall with the white spray bottle. At 7:51:24 AM, V26 went inside R6's room and leaves room at 7:51:38 AM. At 7:52:04 AM, V26 gets into the elevator. At 8:00:50 AM, V26 (former Restorative Aide) emerges from the elevator and returns to the unit. Paramedics arrive on scene at 8:09:56 AM. R6 went onto their stretcher at 8:10:59 AM and R6 is in the elevator at 8:12:46 AM. V26 remained on the unit with other residents.

On 1/5/2024 at 11:22 AM, surveyor reviewed the Fourth Floor West Hall camera angle surveillance footage with V3 (Director of Nursing), V25

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S9999	Continued From page 9 (Assistant Administrator-in-training), and V45 (Human Resources). V26 is at the top of the frame. Housekeeping cart is behind V26. View of the left side of hall near nurses' station is blocked by an open door. At 7:31:29 AM, V26 is standing near the elevators. V26 then starts moving left with right hand up. V45 stated, "Yeah, I see [V26] go forward and bring that right hand up." On 1/5/2024 at 11:30 AM, surveyor reviewed the Fourth Floor East Hall camera angle surveillance footage with V3, V25, and V45. At 7:31:29 AM, V26 brings up the right arm as V26 moves left. V45 stated, "[V26] brought [V26's] right hand up after [R6] stepped forward." V26's Employee Report documents in part: "Investigation Review that something was sprayed, and several staff were coughing. Witness statement indicate that employee did spray pepper spray at resident." R6's 11/15/2023 ambulance records (page 2 of 6) document in part: "[Patient] is complaining of eye pain from being maced. [Patient] appears to have been maced. [Patient] is coughing and [patient's] eyes are irritated. Scene smells like mace was discharged." R6's 11/15/2023 hospital records document in part: "Patient was pepper sprayed. When I reevaluated the patient, patient reports persistent pain in [R6's] left eye after irrigation" (page 3 of 16). "[Patient] was reportedly maced by [Nursing Home] staff. [Patient] arrives with red, irritated face and eyes. [Positive] tearing. [Positive] pain" (Page 6 of 16). V26 signed Receipt and Acknowledgement Employee Handbook - Local No. 4 (11/99) on	S9999		

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S9999	Continued From page 10 11/16/2011. V26 signed Certificate of Receipt of Employee Handbook on 3/8/2013. V26 signed additional Code of Conduct Attestation Statement on 4/5/2013. Facility's Employee Handbook dated 6/11/2021 documents in part: "The Facility will not tolerate any physical, verbal or mental abuse, bullying, or intimidation 'Workplace Violence' whether of residents, patients, employees, visitors, vendors, and/or volunteers. We do not tolerate fighting (physical or verbal) or disorderly conduct on the job. In addition, we prohibit the possession of firearms, knives, or any other weapon on company property or while conducting business on behalf of the Company" (page 14). V26's signed Compliance/False Claims Act/Ethics Program and Code of Conduct Employee Understanding Agreement dated 11/15/2013 documents in part: Don't "mistreat a resident in any way." V26 signed facility's educational in-service for "Managing Difficult Behaviors" on 02/07/2023. Slide 23 titled "10 Tips for Communication" documents in part: "Set a positive mood for interaction. Watch your body language and verbal tone." "When the going gets tough, distract and redirect." Slide 24 titled "Specific Strategies-Agitation" document in part: "Distract the persons with an activity or snack. Confronting a confused person increases anxiety." "Allow the person to do as much for themselves as possible. Support independence." Facility's "Abuse Prevention Program" last revised 03/08/2016 documents in part: "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits	S9999		

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mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment." "Abuse is any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish." "The facility will take steps to prevent potential abuse while the investigation is underway." "Employees of this facility who have been accused of abuse, neglect, mistreatment or misappropriation of resident property will be removed from the resident contact immediately until the results of the investigation have been reviewed by the administrator."
(A)

Statement of Licensure Violations (2 of 3):

300.610a)
300.690a)
300.1010h)
300.1210b)
300.1210d)6)

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

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S9999	Continued From page 12 the facility. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 13 seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to have a nurse assess a resident (R1) immediately after a fall and notify the physician. This resulted in a delay of care for R1 who sustained a displaced fracture of the greater trochanter of the right femur (right hip fracture) from the fall. R1 required surgical intervention. This affected one of six residents reviewed for falls. Findings include: R1's face sheet documents in part medical diagnoses of displaced fracture of greater trochanter of right femur and history of falling. On 1/2/2024 at 11:29 AM, R7 stated R1 fell while staff were trying to help R1 get into the shower. R7 stated R1 kept backing up, slipped, and fell between the footboard and the wall. During a follow-up interview on 1/3/2024 at 10:02 AM, R7 stated, "[R1] was trying to get away from those ladies that wanted to give [R1] a shower. [R1] slipped some sort of way and hurt [R1's] back." R7 stated, "[R1] was hurting on [R1's] side down to [R1's] feet. [R1] was shaking and hollering." R7 stated the facility did not send the resident out until later in the day.	S9999		

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S9999	Continued From page 14 On 1/2/2024 at 11:51 AM, V9 (Restorative Aide) stated staff tried to assist R1 with incontinence care because R1 had soiled pants. V9 stated R1 got up and walked around the bed and when R1 came around the bed, R1 slipped to the wall and slid onto the floor. V9 stated R1 complained of hip pain but didn't say which hip. V9 called for help and staff got R1 up. During a follow-up interview on 1/3/2024 at 9:22 AM, V9 stated, "When [R1] slid down, [R1] laid flat on the floor then [R1] was like 'oh I broke my hip.' [R1] slid all the way to the floor and was hollering that [R1's] hip was broke." V9 stated staff used a draw sheet to get R1 off the floor. V9 stated R1 complained of pain at the time of transfer from floor to bed. On 1/3/2024 at 11:11 AM, V29 (Certified Nurse Aide) stated staff were trying to give R1 a shower around 1:00 PM on 12/15/23. R1 declined so V29 removed gloves and began to exit the room. When V29 turned back around, R1 was sitting on the floor. V29 did not witness how R1 got to the floor but stated R1 stumbled between the footboard and wall. V29 got additional help and assisted R1 back in bed. V29 stated R1 complained of leg pain. Surveyor interviewed V32 (R1's Day Nurse during time of incident) on 1/3/2024 at 2:45 PM. V32 stated staff did not inform [V32] that R1 fell. V32 stated, "I don't know about a fall. Nobody called me for anything. I don't know anything about a fall." Reviewed facility's nursing schedule for 12/15/2023 showed V32 was the only nurse listed for the unit. R1's day shift (7:00 AM - 7:00 PM) progress	S9999		

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notes for 12/15/2023 show no documentation of R1's fall, which V29 stated occurred around 1:00 PM. No documentation of staff's assessments immediately post fall.

On 1/3/2024 at 11:26 AM, V20 (Certified Nurse Aide) stated [V20] took over R1's care for the evening shift (3:00 PM to 11:30 PM). V20 stated staff did not inform [V20] that R1 fell.

On 1/3/2024 at 11:48 AM, V33 (Night Nurse) stated [V33] took over R1's care at 7:00 PM. V33 did not receive shift-to-shift nurse report that R1 fell. At around 9:00 PM, R1 complained of pain and stated [R1] fell when it was still daylight. V33's progress note dated 12/15/2023 9:29 PM documents in part: "upon medication administration resident verbalized [R1] is experiencing pain to bilateral hips and [R1] is unable to move them. Resident was asked if [R1] fell and per resident [R1] believe [R1] fell earlier in the day when it was day light."

On 1/4/2024 at 1:21 PM, V40 (Facility's onsite Nurse Practitioner) stated staff did not notify (V40) of R1's fall.

On 1/5/2024 at 12:47 PM, V43 (Physician) stated staff should have sent R1 to the hospital when [R1] fell and complained of pain. "If they would have notified me, I would have sent [R1] out."

On 1/4/2024 at 10:06 AM, V36 (Fall/Restorative Nurse) stated if an aide witnesses a fall, the aide must first get the nurse before getting the resident up. The nurse assesses the resident and their pain. The nurse looks for redness, warmth, shortening, or rotation. V36 stated, "They don't lift the resident until assessment is completed by the nurse because what if they had a fracture or

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dislocation and you lift the resident then you might make it worst. Depending on the nurse's assessment, the nurse will either call the doctor or send the resident out to hospital right away".

On 1/9/2024 at 12:08 PM, V3 (Director of Nursing) stated if a resident is on the floor and complains of pain, [V3] would assess the resident and call 911. V3 would not transfer or move the resident for safety purposes.

R1's 12/16/23 hospital records documents in part, when R1 arrived in the emergency department, R1 had right hip deformity with right lower extremity shortened and externally rotated (page 25 of 99). The x-ray of the hip revealed an "acute comminuted intertrochanteric fracture of the right proximal femur. Mild displacement of the fracture fragments. Mild valgus angulation" (page 26 of 99). Orthopedic consultation documents in part right hip fracture requiring Open Reduction Internal Fixation (ORIF) surgery on 12/16/2023 (pages 4-5 of 99).

R1's comprehensive care plan contains a focus last revised on 11/27/2023 which documents in part: "[R1] is High Risk for falls [related to] Gait/balance problems, poor safety awareness due to impaired cognition, use of psychotropic medication, poor safety awareness." Interventions initiated 6/21/2021 documents in part: "Follow facility fall protocol."

Facility's "Fall Prevention Policy" last revised 12/20/2022 documents in part: "If a resident experiences a fall, nurses will complete an incident report and document the fall in the resident record, as well as the 24-hour report." The policy does not have procedures or protocols on how to care for a resident immediately post

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S9999	Continued From page 17 fall. "Physician Notification Policy" last revised 2020 documents in part: "Physician will be informed of any significant changes in the resident's condition and or any abnormal labs/x-ray results." "Staff will document in the resident's record when a physician is notified including who was notified, date, time, and physician response/plan of care." "Unsuccessful attempts to notify a physician will also be documented with any further actions that are taken by the nursing staff." (A) Statement of Licensure Violations (3 of 3): 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 45 Ill. Reg. 11096, effective August 27, 2021) This requirement is not met as evidenced by: Based on interviews and record reviews, the facility failed to annually review employee files for any disqualifications for two staff members (V10 and V26) reviewed for abuse. Findings include: Surveyor requested to review V10 (Certified Nurse Aide) and V26's (former Restorative Aide) employee files from V1 (Administrator), V2	S9999		

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S9999	Continued From page 18 (Assistant Administrator), V3 (Director of Nursing), and V25 (Assistant Administrator-in-training). On 1/03/2024 at 9:38 AM, V26's employee file, Health Care Worker Background Check results dated 12/10/2011 1:41 AM documents in part: no disqualifying offenses found. On 1/03/2024 at 11:56 AM, V10's employee file showed the facility last checked the Health Care Worker Registry for V10 on 8/15/2022. On 1/03/2024 at 2:49 PM, V3 stated facility's Human Resources Department did not check V10 or V26 against the registry within the past year. Human Resources was not aware they had to check the registry annually. On 01/09/2024 at 11:32 AM, V45 (Human Resources) stated V45 was new to the facility and started May of 2023. V45 stated facility is supposed to run the Health Care Worker Registry annually to check for disqualifying offenses. V45 does not know why facility was not doing it prior. Facility's untitled and undated policy regarding employment background screening checks does not document in part protocols to ensure continuing eligibility to work for all its employees annually. (C)	S9999		