STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE NURSING PAVILION	2242 NORTH KEDZIE CHICAGO, IL 60647

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S 000	Initial Comments Facility Reported Incident of December 11, 2020 #IL129625	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.3240 a) 300.3240 b) 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. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. Based on interview and record review, the facility failed to protect and prevent a cognitively	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 impaired, non-verbal resident, with behaviors, from physical abuse. A Certified Nursing Assistant held a resident down against his will. As a result, R1 was noted with bruising from his left arm to his shoulder after the incident occurred. This failure affects one of three residents, (R1) in a total sample of three residents. Findings include: R1 is a 66 year old male resident of the facility. R1 has the following diagnoses: stroke, attention and concentration deficit after stroke, dementia, major depression disorder, impulse disorders, abnormalities of gait and mobility, cognitive communication deficit, mood disorder, and difficulty swallowing. R1's Brief Review of Mental Status (BIMS) notes R1 is not alert or oriented. R1 is severely cognitively impaired. R1's care plan notes the following: he speaks very little, he has behaviors that could increase the risk for potential for abuse or neglect; dementia, impaired cognition, depression, non-verbal, and history of substance abuse. He presents with signs and symptoms of depression due to memory deficits, multiple health problems, and loss of independence. Progress notes, dated 12/11/2020, notes staff reported resident has discoloration at left upper arm and bilateral hands. Staff assessed resident head to toe; discoloration to left upper arm and bilateral hands. Range of motion checked. No discomfort or grimacing noted. No further discoloration or injuries noted. Resident is unable to describe occurrence. Initial report, dated 12/11/2020, notes V3's, Former Certified Nursing Assistant (CNA),	S9999		

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S9999	Continued From page 2	S9999		

statement. On Wednesday 12/09/2020, I gave R1 a shower at 9:00AM. R1 was resistant and I sat him in the shower chair. R1 attempted to get up and I held him down to prevent him from falling. I was shaving him and he was fighting me. I just held him down until I was done. I did not have any intention of hurting him. Final report, dated 12/15/2020, notes V4 (Licensed Practical Nurse, LPN) reported to V1 (Administrator) R1 was noted by V6 (CNA) to have bruising on his left upper arm to his shoulder. On 12/14/2020, V1 interviewed fourth floor staff one by one. Cameras were reviewed. On 12/09/2020, V3 was seen taking R1 to the shower room. R1 was being resistant to enter the shower room. V3 stated that R1 was refusing him from removing his gown and he sat him on the shower chair to remove his gown and bathe him. R1 was attempting to get up and he held him down with one hand to keep him from falling. V3 states he was not trying to hurt him, but was trying to keep him from falling. He did not realize that he was using too much force and was very sorry for any harm he may have caused. The facility determined that V3 did not have the intention to hurt R1 on 12/09/2020, during the shower, but the fact that he did not report the incident to his superiors is unacceptable. Abuse is substantiated. Progress note, dated 12/17/2020, R1 was observed grimacing when touching or moving his left arm, referral to therapy for evaluation. Pain medication given. V3 could not be contacted during this investigation.

On 12/31/2020,at 10:48AM, V4 stated, If a resident is combative, we are not supposed to shower them. We are supposed are to ask for help by pulling the call light. Everyone knows this. We can scream and ask for help. There is always plenty of staff in the building and someone could

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come to help. I worked double shift, the day of the incident. It was in evening. V6 reported to me. She was changing the resident and she noticed the bruising on his left arm. I had to make an incident report and report immediately to V1 because R1 could not let us know what happened. When I assessed him, he was not grimacing in the face. He does not know how to express himself. Staff need to talk to him when he becomes combative."

On 12/31/2020 at 11:06AM, V5 (CNA) stated, "If a resident becomes combative during a shower I inform the nurse. I let the resident be or try to finish the shower. If the resident cannot say if he/she wants to finish the shower, hold the resident to make sure they do not fall. I need to report to the nurse. The importance of reporting to the nurse is if the resident falls, it will be documented."

On 12/31/2020 at 11:52AM, V6 stated, "About three weeks ago. I was providing care to R1. I was changing him and putting him to bed. In was in the process of changing him, I saw bruising on left hand. I called V4. She came immediately. If a resident becomes combative, I will leave them if they are comfortable. I will come back and then offer shower again. When they are friendlier and try to offer again. I cannot hold the resident down. I usually pull the alarm. If I cannot leave them alone, I will call for help."

On 12/31/2020 at 12:01PM, V7 (Director of Nursing) stated, "I expect the CNAs to report to nurses to get more assistance. Give the combative residents more time to be redirected. If they cannot be redirected, they need to get assistance from other staff. I do not expect my staff at any time to hold down residents. The

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resident could be injured unknowingly. Always give the resident space. Staff are supposed to pull the call light if a resident becomes combative. R1 is a dementia resident. He is confused. He can become combative. He is redirect-able. There is a risk of injury because we wouldn't know or the type of behavior. We would not be able to do any interventions for this residents. After this incident, have two CNAs assist when showering now as an intervention."

On 12/31/2020 at 12:07PM, V1 stated, "If abuse is substantiated, the employee is terminated. I have never had incidents involving V3. He was aware this happened and he did not report to anyone. He stated R1 was slipping and he did not want him to slip from chair. He stated he held him. I stated he used to much force. If a resident is combative, they need to use the call light and call for help. With the dementia residents, staff need to work with them when they are more at ease. The staff do know who is going to give him/her a harder time. While reviewing the camera footage, I saw that R1 was resistant to showering. I told him not to come. V3 should have told us what occurred. Any incident as small as it is, need to be reported. I do not expect my staff to use force at any time. I would rather the resident to miss his shower to keep him safe. My responsibility to keep residents safe, staff follow the protocols, report to IDPH (Illinois Department of Public Health) right away while I gather information, and protect the resident. Also, get the staff involved out of the building."

Interventions from R1's care plan include: approach in a friendly, calm manner, treat with respect and dignity, communicate with the resident regarding to his capabilities and needs, cue, reorient, and supervise as needed, monitor,

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S9999	Continued From page 5 document, report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and mental status. Facility Abuse Policy, dated 01/2017, notes abuse means any physical or mental injury 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 physical harm, pain, or mental anguish. Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about or suspect to a supervisor or the administrator or local police as soon as possible at the time of the occurrence. (B)	S9999		