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	IL6005912	A. BUILDING: _____ B. WING _____	05/10/2018

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PRESENCE MCAULEY MANOR	400 WEST SULLIVAN ROAD AURORA, IL 60506

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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b) 300.3210g) 300.3240a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.3210 General g) The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints. (Section 2-103 of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 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 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)	S9999		

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These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility staff failed to immediately report multiple allegations of physical abuse and theft per the facility policy.

This failure resulted in the psychosocial harm of a resident who was repeatedly exposed to his alleged abuser and showed symptoms of fear, anger and behaviors.

This applies to 3 of 3 residents (R30, R37 and R13) reviewed for abuse in a sample of 12.

The findings include:

1) Face sheet, undated, shows R30 was admitted on April 12, 2018 and diagnoses include acute respiratory failure, chronic obstructive pulmonary disease, encephalopathy, and weakness. ADL (Activities of Daily Living) care plan, dated April 25, 2018, shows R30 required the extensive to total assistance of one to two staff for all ADLs and required one to one feeding for all meals. MDS (Minimum Data Sheet), dated April 19, 2018, shows R30's cognition was severely impaired.

Facility email dated April 27, 2018, showed R30 moved rooms for continuous monitoring related to falls.

On May 9, 2018 at 11:49 AM, V12 (Family) stated on an afternoon prior to April 27, 2018, V12 entered R30's room and he (R30) seemed really frustrated. V16 (CNA) had just finished feeding the resident dinner and stated, "Your dad has

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been really crazy today. He spit his food at me." R30 stated to his family, "That bitch just hit me in the mouth." Later when V16 came into R30's room and he began shouting, "No! No! Get her away from me!" V12 stated she reported R30's allegation and his apparent frustration to V23 (Registered Nurse) that evening who only replied, "He's been screaming all day ...." V12 stated V16 continued to be assigned to the resident (R30) after the family member reported the incident to V23 and after the family member requested V16 not to be assigned to R30. V12 stated the resident would yell when V16 was near him and would yell, "Get the hell away from me!" R30 would use his hand and swat V16 out of the room or push V16 away. V12 stated R30's hygiene began to deteriorate and V16 told the family member, "He won't let me by him. He don't want us to touch him. He don't want us to clean him up ...." V12 stated she thought V23 told facility administration about the alleged abuse and would ask staff why V16 would still be assigned to R30. On May 2, 2018 the family member (V12) discussed her concern with V18 (CNA). V18 suggested that she should report the information to a supervisor. V12 stated, "No one seemed to want to hear what I wanted to say. No one took action. No one asked who, when ....." On May 5, 2018 when V12 and the resident (R30) were outside visiting, a man approached the family member (V12) and reported an investigation was beginning for R30 and asked if V12 wanted to file a police report to which V12 answered "yes". V15 (Admissions) provided a facility concern form to V12 in an envelope. V12 was told to fill out the concern form, and then return it to the facility. V12 stated R30 allows other CNAs, other than V16, to care for him. V12 stated R30 has shown a great amount of anger and frustration.

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Facility Nursing Assignment schedules, dated April 27, 2018 to May 5, 2018, show V16 worked shifts on the same floor as R30 on April 27, 28, 29, and 30, 2018, and May 1, 2, 3, and 5, 2018.

On May 8, 2018 at 10:18 AM, V2 (Director of Nursing) stated on May 5, 2018 the housekeeper went to clean R30's room, and R30 reported to housekeeper a CNA (Certified Nursing Assistant) was hitting resident. V2 stated she spoke with V13 (another Family member) who reported R30 stated an aide hit him approximately a week and a half ago. V2 stated V10 (Restorative Nurse, Manager) reported the CNA to the agency and asked if the family wanted to file a police report, which the family declined to do.

On May 8, 2018 at 11:10 AM, V18 (CNA) stated on May 5, 2018, V19 (Housekeeping) told V18 that R30 stated he was slapped by his aide. V18 stated she remembered earlier that week R30's family repeatedly told her (V18) that V16 slapped R30. V18 stated she then approached V15 (Admissions / Manager on Duty, for May 5, 2018) to report the current and prior allegations of abuse regarding R30. V18 stated the allegations of abuse began approximately a week and a half ago when family members (V12 and V13) both told V18 on different occasions that R30 reported being slapped by the CNA. Both family members stated the Aide who slapped the resident was V16 and gave a description of the CNA. V18 stated the family members reported R30 recognizes V16's voice and the "voice makes R30 crazy" and R30 says "get that bitch out of here!" when he hears it. V18 stated the family members noticed his behaviors escalate when he hears her voice. V18 stated that multiple staff members including V20 (CNA) and V21 (CNA) reported being told about abuse allegation by R30's family on May 2,

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2018. V18 stated she told V15 (Admission) about V20 and V21's knowledge of the abuse allegations on May 2, 2018. V18 stated she first reported it to facility administration on Saturday after V19 (Housekeeper) approached her (V18) and told her of R30's allegations. V18 stated V19 was panicking and was not sure what to do with the information.

On 05/08/18 at 11:21 AM, V19 (Housekeeper) stated on May 5, 2018, the resident (R30) told him (V19) he was being hit by his aide. He (V19) stated he could not remember to whom in the facility he needed to report allegations of abuse. He (V19) stated, "I don't think I reported it to anybody. I didn't know who to talk to. I just found the first person I saw." V19 stated he later wrote the concern on a facility concern form.

On 05/08/18, V15 (Admissions) stated V19 (Housekeeping) did not verbally report the abuse allegation to facility management prior to getting the concern form.

On 05/08/18 at 10:48 AM, V10 (Restorative Nurse, Manager) stated she sent V16 home on May 5, 2018 however V10 did not call the agency and report V16's allegation of abuse.

On 05/08/18 at 11:02 AM, V17 (CNA Scheduler) stated she did not call the CNA agency to report the allegation of abuse against V16.

On 05/08/18 at 11:51 AM, V22 (Staffing Agency Regional Support) stated no one reported any allegation of abuse against V16 until 05/08/18. V22 stated since the allegation was reported earlier that day, the agency suspended V16 until the investigation was over or pending the outcome

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S9999	Continued From page 6 On May 8, 2018 at 1:11 PM, V1 (Acting Administrator) stated the allegation a staff member hitting/slapping a resident in the face should have been reported to the police per the facility policy on physical abuse allegations. Initial Report of Allegation of Alleged Physical Abuse, dated May 5, 2018, shows IDPH (Illinois Department of Public Health) was notified regarding an allegation of physical abuse, date unknown, by V16 on May 5, 2018. The Report shows the family requested the police not be notified. Concerns and Resolutions Form, dated May 5, 2018, shows R30 stated a CNA slapped him (R30) in the mouth for spitting out food/beverage to V21 (CNA) on May 2, 2018. Concerns and Resolutions Form, dated May 5, 2018, shows on May 2, 2018 at 9:00 PM, R30's family told V20 (CNA) an aide hit R30 in the mouth at some time. Concerns and Resolutions Form, dated May 5, 2018, shows R30's two family members (V12 and V13) V18 (CNA) on two occasions that an agency aide slapped him. V18 stated they both gave the same description of the aide and pointed the aide out. V18 stated V12 and V13 tells her all the time about the abuse and May 2, 2018 was the last time she heard the allegation. Concerns and Resolutions Form, dated May 5, 2018, shows R30 reported he was being hit by his aide to V19 (Housekeeping). 2. Face sheet, undated, shows R37 was admitted on September 24, 2018 and his	S9999		

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diagnoses included gastrointestinal hemorrhage and peptic ulcer. MDS, dated April 24, 2018, shows R37's cognition was intact.

Nursing notes written by V23 (RN -Registered Nurse), dated April 20, 2018, shows, "late entry 4/19/18 (at) 2100 (9:00 PM) resident wheeled himself to nurses station and reports missing forty dollars and IPOD and his identification card after V18 (CNA) gave the shower. Stated that he will call police to report. Explained not to call police we need investigation here in facility first. This RN searched the stuff that resident stated missing unable to find in his room. 2130 (9:30 PM) notified V10 (Restorative Nurse, Manager) on call RN about the complaint of the resident, received instruction to tell resident that we have to investigate in the AM, our administrator will see him. Resident verbalized understanding .... Left message note to social services ..... Endorsed to next shift."

On May 8, 2018 at 2:28 PM, V1 (Acting Administrator) stated he spoke with R37 and followed up on the April 20, 2018 missing items. V1 stated R37 verified the items were still missing. V1 confirmed no abuse report, concern form, or investigation was begun regarding the allegation of R37's missing items. V1 confirmed the allegations of missing items were not reported to IDPH or the police.

3. On May 8, 2018 at 12:21 PM, R13 stated during October 2017, R13 reported to the facility that she was missing two gift certificates, money and a credit card during her stay at the facility. Review of abuse investigation, dated December 11, 2017, shows R13's POA (Power of Attorney) called the facility to inform the Social Worker that R13's credit card was allegedly flagged for

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unauthorized credit card transactions. The report shows a police report was filed by the POA and Discover credit card company opened up an investigation. The facility did not contact the police regarding the missing money/credit card/gift certificates.

Facility Policy Reporting and Investigation of Abuse, Neglect and /or Misappropriation of Resident Property, dated November 28, 2018, shows, "Physical abuse is defined as infliction of injury on a patient/resident that occurs other than by accidental means and that required (whether or not actually given) medical attention and includes hitting, slapping, pinching, kicking, etc .... Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent .... The administrator/designee, on becoming aware of alleged abuse, neglect and/or misappropriation of a resident's property, shall report the matter immediately by telephone to the following: ....v. Local police department (if sexual or physical abuse) ...."

Facility Policy Reporting Reasonable Suspicion of a Crime, dated August 14, 2012, shows, "It is the policy of [the facility] to report any reasonable suspicion of a crime to the local law enforcement agency and the Department of Public Health .... All crimes or suspicion of a crime against a patient or resident shall be immediately reported to the ministry designee for investigation. The person(s) who are reporting may also notify the local law enforcement agency and the Department of Public Health either by telephone, fax or email .... The ministry cannot prohibit an individual reporting directly to the local law

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S9999	Continued From page 9 enforcement agency or the Department of Public Health if a multiple-person report is filed .... F. If the investigation reveals no serious bodily injury, the ministry will report the incident not later than twenty-four hours after forming the suspicion to the ministry's local law enforcement and the Department of Public Health. G. Examples of non-bodily injury suspicion of a crime may include but not limited to: 1) Theft or resident property .... J. Each ministry will coordinate with their local law enforcement agency to determine what actions are considered to be a reportable crime. A list will be maintained, at the ministry, as a guideline to be utilized for reporting." No list of reportable crimes was included as an attachment. (B)	S9999		