| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6006688 | A. BUILDING: _____ B. WING _____ | C 07/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BETHESDA REHAB & SENIOR CARE | 2833 NORTH NORDICA AVENUE CHICAGO, IL 60634 |

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| S 000 | Initial Comments<br><br>Complaint Investigation:<br><br>2183857/IL134584 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)3)5)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care needs of the resident.<br><br>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:<br><br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to protect a resident's right to be free of abuse for one resident (R4) in the sample. This failure affected R4 who asked to | S9999 | | |

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| S9999 | Continued From page 2<br>have care assessment done after finishing lunch that escalated into verbal and mental abuse. This failure resulted in R4 crying, being upset and feeling hurt. This has the potential to affect all 16 residents residing on the 1st floor of the facility.<br><br>Findings include:<br><br>On 6/21/21 at 12:47pm, during lunch time observation, R4 was noted eating lunch in the dining area on the 1st floor. R4 explained to the surveyor that after being admitted to the facility (R4) developed a pressure ulcer to the right buttocks because at the time (R4) was unable to move about freely and had difficulty turning in bed. R4 stated it takes from 20 to 45 minutes before any staff come to help using the call light. R4 stated I developed redness to the back of my thigh from sitting on a commode for a long time. R4 then tried to show the surveyor the pressure site while in the dining room. The surveyor agreed with R4 that after R4 finished eating lunch, the nurse will come with the surveyor to look at the site. The surveyor notified V22 RN (Registered Nurse) in charge of the floor about checking R4's pressure sites after lunch. V22 stated she was supposed to do the treatment to the site and was busy, so she did not know how the site looks.<br><br>On 6/21/2021 at 1:17pm, V22 came into the dining area, in a loud harsh voice and asked R4 to go into the room so the pressure site can be looked at. R4 was still eating at this time. V22 then in a loud and harsh voice told R4 to get up now and go back to R4's room. R4 tried explaining to V22, that the surveyor agreed to wait till after lunch. V22 said to R4 still in a loud harsh voice that she has no patience for R4's behavior and if R4 did not get up to go in the room now, she will leave and the treatment will | S9999 | | |

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| S9999 | Continued From page 3 | S9999 | | |

not be done. R4 then turn to the surveyor and said, "do you see how (V22) is talking to me?" and tears began to run down R4's face. R4 stated "This is the way they treat me like I don't mean nothing". R4 continued to cry. V22 then replied to R4, "I'm sure she (referring to the surveyor) is not hard of hearing, yes she can hear me." V22 then walked away and told R4 and the surveyor "I guess she (referring to the surveyor) will not see the sites because this is the time I have for her to see it". V22 then turned and left the dining area. At 1:23pm, the surveyor made this incident known to V1 (Administrator), V3 (Cooperate Director of Nursing), and V17 DON (Director of Nurse's).

On 6/21/2021 at 2:13pm, R4 expressed gratitude of thanks to the State Agency stated that "I feel better now, that V22 was sent home." R4 told the surveyor "you did the right thing. If you are not here (referring to the facility) no-one will do anything about it. They will cover for themselves and that is why I reported to the State Agency because I'm sure they will do something about it. I'm worried about others (referring to peers) who cannot speak for themselves. Thanks, Thanks."

The facility policy presented on "Resident Rights" with revised date November 2020 documented that employees shall treat all residents with kindness, respect and dignity, and will observe and honor the Resident's Bill of Rights in their conduct as an employee. Procedures pointed out that the Federal and State laws guarantee certain basic rights to all residents of the facility and the listed rights include but not limited to residents are fully entitled to exercise their rights and privileges possible. The facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated

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| S9999 | Continued From page 4<br>with respect, kindness and dignity.<br><br>The facility policy titled "Abuse and Neglect Policy and Procedure" with revised date 1/17/19 documented that the purpose is to outline guidelines for prevention of resident abuse and measures to be taken in the event any kind of resident abuse is suspected or identified. The policy pointed out in part that all resident have the right to be free from abuse by anyone, including but not limited to facility staff, other resident, consultants, volunteers, staff of other agencies, family members, friends or other individuals. The policy listed out forms of abuse that includes but not limited to mistreatment, mental abuse and verbal abuse. The policy documented in part that mental abuse includes but not limited to treatment of a resident in a way that makes them feel inferior, causing them to have hurt feelings. The policy indicated in part that verbal abuse example includes but not limited to speaking harshly, blaming the resident and making statements that cause a resident to feel intimidated or threatened.<br>(B) | S9999 | | |