STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001002	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.3240f) 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 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. Section 300.3240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure two residents (R101 & R176) were free from physical abuse by R89 who has a history of physical aggression. The facility also failed to ensure interventions were in place for R89 after he physically abused R176 resulting in R101 being physically abused 20 days later. This failure resulted in R176 having a bruised eye and R101 having a bruised arm. This applies to 3 of 3 residents (R89, R101, & R176) reviewed for physical abuse in the sample of 35. The findings include: R89's electronic medical record (EMR) shows, he was admitted to the facility on July 12, 2021 from another local nursing home. His diagnoses include; cannabis use, alcohol abuse with intoxication, nicotine dependence, schizophrenia, hallucinations, seizures, and major depressive disorder. R89's referral admission paperwork from the local nursing home documents his aggressive behaviors prior to being admitted to the facility. The progress notes show the following: "July 7, 2021: Patient alert with periods of confusion. Patient showed signs of irritation this morning	S9999		

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when being assisted with daily needs. Patient began to swear at staff then stood up and began to urinate on his bed. Patient ignored staff attempting to assist him ... July 3, 2021: Patient is on unit wandering in and out of other residents' room. Patient has exit seeking behaviors and is becoming increasingly agitated, unable to redirect, behavior patient complained of some people sleeping in his room and he has to sleep on the couch, patient does not have couch in room and was observed lying in bed in AM ... July 3, 2021: patient noted coming out of a female resident's room with a rolled up a linen ... July 3, 2021: nurse on duty (NOD) notified by another patient that R89 was in and out of her room multiple times rummaging through her stuff. Resident said that R89 did not physically touch her, female patient said no... June 20, 2021: ...patient started behaviors this morning by walking into other patient's room and had to be advised and redirected by staff that he is not allowed to go into other patients' rooms without permission. Pt (patient) repeatedly insisted doing so, several pts complained of pt. being in their room. Early afternoon, pt. attempted to leave facility by going down the stairs, CNA (Certified Nursing Assistant) redirected pt. back to 2nd floor and pt. held onto CNA arm and pulled her stating "you are coming with me." Pt. back to floor and became aggressive with nurse by pulling on her computer cord and taking her belongings. Writer administered PRN (when needed) Ativan; pt. spit out. Writer advised pt. needs medication for anxiety; pt. took medication. Writer called primary physician to make aware that pt. is being unsafe to self, staff and patients-new order to send pt. if behaviors continue. June 20, 2021: Pt. sent to local hospital for psych evaluation ... June 20, 2021: Received call from patient's brother, who expressed concern for his brother

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S9999	Continued From page 3 getting proper psych evaluation and shared concerns of past behaviors patient exhibited that are similar to behaviors patient is exhibiting now. June 6, 2021: Resident was lying on edge of bed. NOD and CNA attempting to straighten resident in bed. Resident became very combative and verbally abusive. Resident threatened to hit NOD. Resident verbalized "I will hit you in head with shovel" Resident attempted to hit NOD with his fist..." R89's current facility progress notes, dated July 12, 2021, shows "Resident admitted from local nursing home, alert and oriented x 2 to name and place with periods of confusion ..." R89's progress notes dated July 15, 2021 shows, "Behavior note: Resident is alert and oriented x1 self only. Wanders and hard to redirect. Goes inside other residents' room and touches their things." R89's progress notes dated July 16, 2021 shows, "Resident was sent out on involuntary petition yesterday after having hallucinations and wandering into other resident's rooms. He made allegation that co peer made contact with him while in the room." R89's progress notes dated July 27, 2021 shows, "Readmission follow up ... Patient alert oriented x1 to person, confused and agitated. Wanders and exit seeking. Difficult to redirect. Goes inside other patients' room and try to touch their things ..." R89's progress notes dated July 28, 2021 shows, "Resident shows aggressive behavior to caretaker, going to other resident's room ..."	S9999		

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R89's incident report provided by the facility for physical abuse dated August 22, 2021 shows, "Staff heard someone screaming and noted resident (R89) inside one of the rooms punching him (R176) on the eye area ... Notes: R89 just had an incident against another resident due to impulsive and sudden outburst by punching him (R176) on his left eye area ..."

The facility's final abuse investigation dated August 22, 2021 shows, "Conclusion: Based on investigation and interviews, resident R89 had an unprovoked aggression and made physical contact with resident R176 ..."

R89's progress notes dated August 22, 2021 shows, "Incident note: patient went to other patients' room and punched him on left eye, resident walked out to the room and does not remember what he did ... Patient (R89) was sent to local hospital ..." The same progress notes show, "the writer got a report from the hospital about resident (R89) that all the psych evaluation was done ...and everything is ok. Doctor cleared him, no new order. Resident (R89) is back at the facility."

On September 29, 2021 at 11:20 AM, R176 stated R89 hit him in the eye. R176 was lying in bed when R89 came into his room. R176 asked R89 to leave and R89 hit him in the eye. R176 had a bruised eye. R176 also stated, "something like that happens, crazy and attack you, how can I feel safe?"

R176's minimum data set (MDS) dated September 1, 2021 shows, he is cognitively intact.

On September 29, 2021 at 12:00 PM, V23

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S9999	Continued From page 5 Registered Nurse (RN) stated she was the nurse the day when R89 hit R176 in the face. V23 said, R176 came out of his room stating R89 hit him in the face. V23 sent R89 to the hospital after that. When he returned from the hospital, he did not have any new orders. R89's intervention was to be 1:1 with staff. Wherever R89 went, a staff member was to be with him. R89's progress notes dated September 3, 2021 shows, "behavior charting: outburst behavioral, with episodes of angriness, and used not appropriate language, combative. Resident was wandering around and went to other residents' room ..." R89's progress notes dated September 11, 2021 shows, "While entering resident room, observed this resident physically aggressive and hitting his roommates..." The facility's abuse investigation dated September 11, 2021 shows, "Brief description of incident: it is alleged that resident R89 made physical contact with resident R101 ..." The same assessment shows, R101 is alert and oriented X2. On September 29, 2021 at 11:30 AM, R101 stated R89 was his roommate. R101 stated when he went into the bathroom, R89 was sitting on his own bed. When R101 came out of the bathroom, R89 was sitting on his (R101's) bed. R101 asked R89 to get off his bed. R89 got mad and hit him in the face, grabbed his arm and started hitting his arm. R101 stated, R89 bruised his arm, and he had a "big bump" on it. R101 also stated, R89 has called him a "nigger" before and he was aware that R89 hit R176 in the face. R101 said he saw R89 go into R176's room "that	S9999		

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S9999	Continued From page 6 day" and then R176 came out saying R89 hit him in the face. On September 29, 2021 at 12:00 PM, V23 RN stated she was R89's nurse in the morning but the incident with R101 happened on the evening shift. She stated, "He (R89) was supposed to be 1:1. He was 1:1 in the morning, I don't know what happened in the evening." R89's screening assessment for aggressive and/or harmful behavior, dated August 23, 2021, shows "Potentially able to integrate with structure, direction, and supportive counseling. (Additional dementia related interventions may include consideration of a more secured unit, dementia focused activities. Additional SMI (serious mental illness) interventions may include limited/supervised community access, group intervention and 1:1 intervention. Incident occurred on: 8/23/2021 with another co-peer resulting in physical aggression ..." R89's EMR did not show any previous screening assessments prior to incident on August 22, 2021. R89's care plan (no date) shows, "Focus: R89 has a history of aggressive inappropriate, attention-seeking and/or maladaptive behavior, but has demonstrated stability during the admission screening process & is therefore considered appropriate for admission. History/presenting includes conflicts or altercations with others." The same assessment also shows, "Focus: R89 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming and problems understanding the immediate environment. Symptoms are manifested by: Pacing roaming or	S9999		

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S9999	Continued From page 7 wandering in and out of peer's rooms, R89 is a new admission and not familiar with his environment and has periods of confusion. Wander guard was placed for safety and visual monitoring/1:1 dependent upon presenting mood/behaviors. Interventions: 1:1 if/as needed if resident is exhibiting increased mood/behaviors when in common areas." The facility's abuse prevention program last revised January 2019 shows, "Policy: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility." (B) Statement of Licensure Violations (2 of 2): Section 300.675 COVID-19 Training Requirements EMERGENCY a) Definitions. For the purposes of this Section, the following terms have the meanings ascribed in this subsection (a): 1) "CMMS Training" means CMMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management, available at https://QSEP.cms.gov. 2) "Frontline clinical staff" means the medical director of the facility, facility treating physicians, registered nurses, licensed practical nurses, certified nurse assistants, psychiatric service rehabilitation aides, rehabilitation therapy aides, psychiatric services rehabilitation coordinators, assistant	S9999		

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S9999	Continued From page 8 directors of nursing, directors of nursing, social service directors, and any licensed physical, occupational or speech therapists. Any consultants, contractors, volunteers, students in any training programs, and caregivers who provide, engage in, or administer direct care and services to residents on behalf of the facility are also considered frontline clinical staff. b) Required Frontline Clinical Staff Training 1) All frontline staff employed by facilities shall complete the following portions of CMMS Training: A) Module 1: Hand Hygiene and PPE; B) Module 2: Screening and Surveillance; C) Module 3: Cleaning the Nursing Home; D) Module 4: Cohorting; and E) Module 5: Caring for Residents with Dementia in a Pandemic. 4) Facilities shall require, within 14 days after hiring, CMMS Training for all management staff hired after January 31, 2021. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to ensure all new hired frontline clinical staff completed the CMMS (Centers for Medicare and Medicaid Services) Targeted COVID-19 Training for Frontline Nursing Home Staff and Management within 14 days after their hire date. This applies to all 188 residents residing in the facility. The CMS-672 form completed by the facility on September 28, 2021 showed the facility had a census of 188 residents.	S9999		

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S9999	Continued From page 9 On September 29, 2021 at 11:00 AM, V1 Administrator stated she recently was made aware of the CMMS training needing to be completed within the first 14 days of hire and did not believe all of the staff had completed the training. On September 22, 2021 at 10:00 AM, V35 Human Resources Coordinator stated I just received an email a few days ago the COVID-19 training needs to be completed within the first 14 days of being hired. V35 stated We are trying to get those who have not competed it in for the training as soon as possible. The Facility's COVID-19 New Hire Certification list from July 19, 2021 through August 28, 2021 showed V36 Social Services, V37 Resident Assistant (RA), V38 RA, V39 Certified Nursing Assistant, and V40 Assistant Director of Nursing did not completed their training within the 14 days after being hired. (C)	S9999		