STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 62960

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S 000	Initial Comments FRI of 10/3/2021/IL139111	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)5) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These Regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free from abuse for 1 of 3 (R2) residents reviewed for abuse in the sample of 6. This failure resulted in R2 being hit by V3 (Registered Nurse) resulting in bruising and scratches on R2's face and neck. Findings Include: R2's facility admission record documents R2 was admitted to the facility on 8/12/2020 with diagnoses that include Peripheral vascular disease, muscle weakness, reduced mobility, Dementia, Psychotic disorder, Schizoaffective disorder, muscle wasting and atrophy, unsteadiness on feet, Alzheimer's disease, Osteoarthritis, and restlessness and agitation. The facility final report not dated, regarding R2, documents under Complete Description of Occurrence, "Alleged Physical Abuse. On 10/03/21 at 1:50 AM V3 (Registered Nurse/RN) was suspended pending investigation for physical abuse. Employee refused drug screening. (local)	S9999		

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S9999	Continued From page 2 Police, family, MD (physician), and Administrator/Abuse Coordinator were notified of occurrence. Complete body assessment performed on resident with injures documented. Facility abuse policy and procedures initiated. Midnight staff interviewed. Resident safety questionnaire completed on five alert residents without any safety concerns voiced. 100% skin audit performed on all residents with no abnormal bruising or injuries noted. All staff inserviced on abuse policy, residents rights, and how to cope with job related stress and burnout. Social service performed follow up interview with resident. Due to diagnosis of Dementia and cognitive declines, resident does not recall event at this time. After completion of investigation, it was determined that the physical abuse allegation was substantiated and employee will be terminated. Resident's family has decided to pursue criminal charges and are working with local law enforcement." R2's resident notes history dated 10/03/21, regarding incident with V3, documents under Nurse's Note, "Nurse (V3) reports that she attempted to redirect resident because he was being destructive to property. She (V3) reports that he (R2) began scratching her (V3) arms and ramming his (R2) wheelchair into her (V3) and continued coming toward her (V3) when she (V3) attempted to back away. Nurse reports that she (V3) pushed his (R2) wheelchair away to end the conflict." Under resident statement it documents, "Resident (R2) stated that this "lady came up from behind and started hitting my neck. Then she hit my ear and then my eye." He reports that he was striking back at her in attempt to get her to "stop wailing on me." Under witness statement it documents, "V7 (Certified Nursing Assistant) was in a room providing care when she heard	S9999		

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resident yelling out for help. States that she entered the hallway and witnessed the RN (V3) holding resident by the back of his neck and witnessed her strike the resident in the right eye. She states that she told the RN (V3) that the behavior was unacceptable and at that time the RN (V3) shoved residents wheelchair with force causing it to propel down the hall and almost tip. V7 (CNA) took resident to the other nurse in the building and the abuse policy was initiated." Under immediate action it documents, "Alleged perpetrator removed from direct care and suspended pending investigation. Complete body assessment performed."

The facility resident (R2) injury history dated 10/03/21 documents the following injury descriptions, left side of neck-superficial scratches, right side of neck- superficial scratches, right eye- redness to corner of eye.

R2's Physician Progress note dated 10/04/21 documents under history of present illness, "This 87 y.o (year old) male was seen at the nursing facility today for medical evaluation after reports of abuse. Facility reports over the weekend staff member evidently grabbed the resident by the back of the neck leaving scratch marks. The resident does have underlying dementia and is a poor historian. He does not recall the event and is not showing any signs of aggression or signs of post traumatic stress at this point." Under physical examination the physician progress note documents "...red marks on anterior side of neck and posterior, superficial, noninfected...."

On 10/13/2021 at 11:10 AM this surveyor attempted to interview R2. He was sitting in bed with lower extremities covered. There were no obvious injuries observed to R2's face. Attempted

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to view R2's neck but R2 did not want me to look at the back of it so this surveyor was unable to determine if the injuries were still visible. R2 was not interviewable. R2 did not appear agitated or afraid during these observations.

On 10/13/21 at 11:27 AM, V7 (CNA) stated she was working the night the incident occurred. V7 sated R2 had been up and roaming about the facility pleasant and not agitated since about 10:00 PM that night. V7 stated V3 (RN) came up and insisted R2 go to bed and swung his wheelchair around and took R2's shoes off. V7 stated she (V7) took R2 to bed and within a short time R2 was observed crawling out of his room and into the hallway so V7 assisted R2 into his wheelchair. V7 stated she (V7) was doing bed checks so she (V7) pushed R2's wheelchair close to where she (V7) was working and went into a room to complete a bed check. V7 stated while in the room she heard R2 yell, "Help me granddaughter. She's beating me." V7 stated she dropped what she was doing and ran into the hallway where she (V7) observed V3 hitting R2 with the flat side of her (V3) fist. V7 stated she (V7) yelled at V3 to stop and turn him (R2) loose. V7 stated V3 was holding the wheelchair and hit R2 in the eye with her (V3) other hand. V7 stated V3 then shoved R2's wheelchair down the hall so fast that when V7 caught him R2 was almost falling out of the chair. V7 stated she ran to the other nurse's station and told the other nurse (V13/RN) what happened. V7 stated V13 called V2 (Interim Director of Nurses) and V2 arrived to the facility in about 7 minutes and V3 was removed from the facility at that time. V7 stated R2 was with staff until V7 was removed from the facility. V7 stated R2 had marks on his ear, his eye was red and puffy, and there were marks on his neck. V7 stated the local police were called

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S9999	Continued From page 5 and arrived to the facility within about ten minutes. On 10/14/21 at 9:55 AM V10 (CNA) stated he was working the night of the incident but did not witness it. V10 stated he was at the nurse's station when V7 came running up and said V3 had hit R2. V10 stated R2 very clearly talked about what had occurred. V10 stated R2 described how he was "battered" on his back, side of his shoulder, side of his head and then on his face across the nose, and onto the eye socket. V10 stated V13 (RN) assessed R2 and you could clearly see the areas he had been hit. On 10/14/21 at 10:58 AM V13 (RN) stated she was working the night the incident occurred. V13 stated all of a sudden V7 (CNA) came running up the hall, she was crying, and said V3 hit R2. V13 stated R2 had some redness around his right eye and on his neck and kept saying she (V3) had hit him. V13 stated she stayed with R2 after the incident was reported to her and V2 arrived to the facility in less than 10 minutes. V13 stated R2 was upset and talked about it for hours after it happened. On 10/13/21 at 11:13 AM V6 (housekeeping/laundry) stated she spoke with R2 the day after the incident occurred (10/4/2021) V6 stated R2 was "fired up" because she (V3) had hit him. V6 stated R2 was trying to hit a peer and was talking about what had occurred. V6 stated R2 told her she (V3) hit him upside the head. On 10/14/21 at 9:45 AM V12 (CNA) stated she provided care to R2 the day after the incident occurred (10/4/2021). When asked how R2 appeared on 10/4/21 V12 stated R2 was very aggressive. V12 stated R2 thought his roommate	S9999		

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S9999	Continued From page 6 was trying to beat him up all day so they moved R2 down the hall to a different room. When asked how R2 did after the move V12 stated R2 wasn't happy and he was talking aggressively. V12 stated R2 kept showing them his pinky finger that had blood around it and his left ear was red. When asked if it was normal for R2 to have aggressive behaviors V12 stated he did when he first moved to the facility but he had not had any recently. V12 stated R2 was in better spirits now than he was the day after the incident occurred. On 10/14/21 at 10:19 AM V2 (RN) stated her title at the time the incident occurred was Interim Director of Nurses. V2 stated she got a call from V13 about 2:00 AM who reported the incident. V2 stated when she got to the facility approximately 10 minutes later V13, V7 and R2 were all together and V3 was outside smoking. V2 sated she met V3 as she was coming into the facility and informed her of the allegation of abuse and that she would be removed from direct care. V3 stated they walked together, counted the narcotics, and then went to her office where she called the local police. V2 stated V3 kept holding her arms out and saying look what he did to me and V2 observed superficial scratches on V3's arms. V2 stated V3 said she was trying to get a baby monitor from R2 and she was trying to protect herself when she shoved his wheelchair away from her. V2 stated V3 was very upset and belligerent. V2 stated after they were finished with the local police they did a thorough skin check on R2 and observed two red areas with scratches on each side of his neck and a slight red mark on his right eye that quickly went away. V2 stated they started the investigation which included interviewing staff and residents, doing skin checks on all of the residents to ensure there were no injuries of unknown origin, and training	S9999		

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all staff. V2 stated after they completed their investigation they determined the allegation of abuse was founded so they called V3 and let her know she was terminated.

On 10/14/21 at 11:14 AM V14 (family member) stated she was notified by the facility of the incident. V14 stated she saw R2 on the Friday after the incident (10/8/21) and he had some "red spotted blood pooled under the skin." V14 stated it looked like bruises/scratched or scraped marks. V14 stated the facility terminated V3 and called the police and she didn't have any concerns with the way the facility handled the incident. V14 stated she had spoke with the police and charges were being filed against V3.

On 10/14/21 at 1:45 PM V1 (Administrator) stated she was out of town when the incident occurred and V2 was responsible for investigating the incident. V1 stated V2 notified her of the incident on 10/3/21 at approximately 2:30 AM. V1 stated V3 was trained on abuse and neglect prior to the incident and all staff have been re-trained after the incident.

The local police report dated 10/03/21 documents "On 10/03/21, at approximately 2:42 AM, the (name of police department) responded to (facility) in regards to staff abuse to a resident. On my arrival, I saw two females standing in front of the entrance to the facility. One of the females approached me and advised she was the Director of Nurses (V2) and was mandated to report the incident. ....V2 stated she received a call from one of the CNA's, informing her about the incident. Before my arrival, V2 had removed a female...(V3), who was the registered nurse involved in the incident....V2 then stated that a CNA (V7) witnessed the end of the altercation

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and confronted V3....We first spoke with the Victim (R2) who is a resident....When R2 was asked about the altercation he went into detail. R2 stated he was sitting at the kitchen table when he confronted a lady who used to work for him. R2 then stated the woman struck him in the back of his neck, struck him in the ear, and then struck him multiple times in the left eye. I observed visible injuries to R2's neck. While describing the actions of the event, R2 was using hand gestures of the motion of someone hitting him in the face. R2 then stated, she whooped my butt. After R2 was finished describing the incident, he was given an orientation test. R2 was asked what year it was currently and who the current President of the United States was? R2 answered the first question with 2000. He answered the second question with yea I don't like the man, he used to work for me....We spoke with V7, the CNA who witnessed the incident. V7 stated she was in room... checking on R2's roommate when she heard a male voice yelling form the hall. When she got out in the hall, she witnessed the charge nurse (V3) strike R2 in the face with an open hand. V7 stated that R2 was trying to grab and push V3 away from him. V7 stated she confronted V3 and V3 advised V7 that R2 had hit her first. V7 stated she told V3 to turn R2 loose and with a running start, V3 shoved R2's wheelchair down the hall. V7 advised the wheelchair rolled down the hall, swerving from side to side. V7 stated she grabbed the handle of the chair to stop him and noticed R2 had nearly slipped out of the wheelchair. V7 stated she pushed R2 to the nearest split in the hallway, where R2 was in the open view while V7 went to the nearest nurses station to report what happened. A charge nurse from another hall called and reported the incident to V2, the Director of Nursing..." The local police report

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S9999	Continued From page 9 documents V3 did not want to speak with them without an attorney present and that V14 wished to pressed charges against V3. Located within the local police report is an affidavit of probable cause dated 10/03/2021 that indicates there is sufficient facts to support a determination that V3 probably committed the crimes of aggravated battery and elderly abuse. The facility Abuse, Prevention and Prohibition Policy dated 11/2018 " documents under statement of intent, "Each resident has the right to be free from abuse, corporal punishment, and involuntary inclusion. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals." Under Policy it documents, "This facility prohibits mistreatment, neglect or abuse of residents..." "B"	S9999		