STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000772	A. BUILDING: _____ B. WING _____	C 05/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HILL	2400 SOUTH FINLEY ROAD LOMBARD, IL 60148

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incidents of: 5/5/2021 / #IL133597 4/29/2021 /#IL133515	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.3240a) 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) Based on interview and record review the facility failed to prevent physical abuse by a staff to a resident during incontinence care of the resident. This applies to 1 of 1 resident (R1) reviewed for physical abuse in a sample of 3. The findings include: R1's face sheet included diagnoses of encounter with palliative care, difficulty walking, unsteadiness on feet, muscle weakness, anxiety, major depressive disorder, osteoarthritis, hypertension, dementia without behavioral disturbances, history of falling. On 5/07/21 at 11:42 AM, V3 (Registered Nurse) stated that on 4/29/21 she was in the hallway across the room from R1 and she saw V4 (Certified Nursing Assistant) entering R1's room to give care. V3 stated that she heard R1 shouting but didn't make anything of it as it was	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 R1's normal behavior during care. V3 stated that V4 came out of the room and asked for a band aide. V3 stated that on enquiry why V4 needed a band aide, V4 told her that R1 scratched her own cheek during care. V3 stated that she went into R1's room to see what had happened and was concerned to find R1's right cheek bleeding into her gown and that the outer layer of the skin had come off. V3 stated that on further examination she saw that R1's mouth had blood and saw that her lips were swollen. V3 stated that V4 then told her that she had covered R1's mouth to keep her from screaming during care. V3 stated that she immediately went to the nurse's station and called for V5 (Registered Nurse) the evening supervisor to come upstairs to assess the situation. V3 stated that V5 took over and after reporting the incident to V2 (Director of Nursing), he escorted V4 out of the facility. On 5/7/21 at 11:19 AM, V2 (Director of Nursing) stated that and she assists with most of the nursing abuse allegations. V2 stated that as soon as V3 (Registered Nurse) reported the staff to resident incident of 4/29/21 to V5 (Registered Nurse), he (V5) notified her by telephone. V2 stated that she in turn reported it to V1 (Administrator) who is the abuse coordinator. On 5/08/21 at 12:00 PM, V1 (Administrator) stated that based on investigations of the 4/29/21 incident, the staff [V4] to resident [R1] abuse was substantiated. V1 stated that V4 was initially suspended pending investigations and terminated over the phone on 5/3/21. V1 stated that although the facility was unable to actually witness the physical abuse, the statement from V4 that she covered R1's mouth was itself enough as that is not allowed, more so in a Dementia unit.	S9999		

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S9999	Continued From page 2 R1's EMR (electronic medical records) included the following: 4/29/2021 11:30 Incident Note: Around 5:15 A.M. 04/29/21 assigned CNA went inside the room of the resident's room of [R1]to do her personal care and about 5:30 a.m. assigned CNA walked out of the room and threw garbage in trash cart and then walked up to this (RN) and requested for a band aid for bleeding to the resident's left face. This writer asked what happened. Assigned CNA stated," the resident scratched her face". Then assigned CNA further mentioned, " I tried to cover her mouth to keep her calm." This (RN) grab wound cleanser and gauze from the treatment cart, anticipating to put pressure r/t [related to]reported bleeding. As this (RN) went into the resident's room to assess resident and noted a 2.5 cm layer of skin missing skin (skin tear), and another linear slits/tears to base and lateral side. The nurse cleansed the area and noted blood in the resident's mouth. This writer completed treatment and immediately notified co - nurse downstairs to help reassess and assist. Co-nurse assessed resident quickly and escorted assigned CNA out of building. Co-nurse right away reported to DON as abuse. Co-nurse informed DON at 0603 a.m. of 04/29/21. 4/29/2021 14:01 Incident Note: alleged abuse resulting in skin tear to left cheek of resident. Also noted dried blood in resident's mouth; unable to clearly assess inside mouth as resident is confused and seemed nervous.... Facility Final IRI report of 5/3/21also included the following: Second skin check completed [of R1] with circular bruise noted to right upper arm 1.2 x 1.3 cm bluish in color with skin intact..."	S9999		

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S9999	Continued From page 3 Personal files for V4 showed that she was hired on 3/23/21 and was terminated on 5/3/21. Facility abuse policy and procedures titled "Resident Abuse/Neglect/Exploitation and Reporting Requirements (revised/reviewed 2/23/17, 1/21/2019) included the following: It is the policy of [facility] to provide an environment that is free from all types of resident abuse, neglect, and/or exploitation by all persons including misappropriation of resident's funds property. Definitions: Abuse is the wilful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish... Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. When intentional it is considered abuse; when unintentional, it is considered neglect. Physical abuse includes hitting, punching, slapping, pinching and kicking. It included controlling behavior through corporal punishment.	S9999		

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