STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003305	A. BUILDING: _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 Complaint Investigation: 2217415/IL151281	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240g) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. c) A facility administrator who becomes aware of	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. d) 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. g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. This REQUIREMENT is not met as evidenced by: A.Based on interview and record review, the facility failed to prevent a resident from being physically, mentally, and verbally abused by a staff member for one of one resident (R1) reviewed for abuse in the sample of 16. This failure resulted in R1 feeling tearful, feeling unsafe, and R1 stating R1 felt like garbage. B. Based on interview and record review, the facility failed to implement abuse policies and procedures after an allegation of abuse was made. The facility failed to do a thorough abuse investigation on two occasions for one resident (R1). The facility also failed to report an abuse allegation to the State Agency for one of one resident (R1) reviewed for abuse in the sample of 16.	S9999		

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S9999	Continued From page 2 The findings include: R1's face sheet showed R1 was admitted to the facility on 8/8/22. R1's diagnosis included morbid obesity, obstructive sleep apnea, chronic kidney disease stage 3, osteoarthritis, respiratory failure, hypertension, and major depressive disorder. R1's care plan and 8/15/22 facility assessment does not show any behaviors. The facility assessment showed R1 was cognitively intact. On 9/20/22 at 9:50 AM, R4 (R1's roommate) said on 9/9/22,V5 (Certified Nursing Assistant/CNA) pushed the walker into R1, and she almost fell. I saw it happen and there was another CNA (V6) in the room also. V5 called R1 "a fat a**". I didn't report it to anyone, but I know R1 and V6 did. It bothered me. R1 was screaming for V5 to get out of our room. V5 wasn't assigned to this hallway. V5 was being nice to me to irritate R1. V5 made it seem like we were great buddies. I don't really know her. I was upset. R1 was upset. V5 came into our room a whole bunch of times that night even after being told to get out. On 9/20/22 at 9:57 AM, R1 said "it was horrible". My roommate saw it and V6 saw it happen. The CNA reported it. From the first day I got here V5 had been bothering me. V5 came up to me the first day and said I hear you don't like CNAs. V5 said she comes into my room to see R4 my roommate. But R4 said she doesn't really know her. On 9/9/22, V5 entered my room to talk to R4. Before she got to R4 I told her we did not want her in our room. V5 entered our room again later and I began screaming at her to get out. V5 said she could be in here if she wanted and she could do whatever she wanted. I tried to block her with	S9999		

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S9999	Continued From page 3	S9999		

my body from entering the room. She entered the room four or five times despite me yelling and telling her to get out. V5 then called me a fat a** and b**ch and pushed my walker into me almost knocking me over. This incident "made me feel like sh**, garbage. I cried I was so upset. I felt like less than what I am". I told V1 (Administrator) about the incident the next day. They wouldn't fire her. They offered to move me to another room or facility. That was disgusting to tell you the truth. I don't feel safe when V5 is around. She intentionally seeks me out and makes sure I see her. V5 comes in my room and down our hall when she isn't even assigned there. V5 even went outside my window and made sure I saw her there.

On 9/20/22 at 10:35 AM, V7 (Licensed Practical Nurse/LPN) said on 9/15/22, V5 was working on another unit and went into R1's room. V5 said she went in to talk to and hug R4. R1 told V5 to get out of the room. R1 was calling for me. When I entered her room, she told me V5 wouldn't leave the room as she asked and called her a child or something. I apologized to R1 and told her I'd tell V5 to stay out of the room. I contacted V2 (Director of Nursing/DON). The DON told me nothing was established after the 9/9/22 incident prohibiting V5 to enter R1's room. I told the DON R1 still doesn't want V5 in her room. V5 going into R1's room was like throwing gasoline onto a fire. That same night, V8 (CNA) couldn't find V5 to assist in transferring R2. I helped with the transfer. When I saw V5, I asked her why she left her work area without telling anyone. Then, V5 went into R2's room and confronted V8 about (arguing in front of R2) about telling V7 she couldn't be found. This upset R2. R2 told me she didn't want V5 in her room the rest of the night. I told V5 to stay out of R2's room. V5 went back

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S9999	Continued From page 4 into R2's room anyway. V7 said, I told V5 just because you think it is okay, it's not okay if I told you to not go in someone's room. V5 always comes up with excuses to her behavior. I called V2 (DON) and V1 (Administrator) to report the incidents. The Administrator said she'd talk to V5. I can't believe she's still employed here. The Administrator is the Abuse Coordinator. On 9/20/22 at 11:15 AM, V8 (CNA) said R1 came up to her crying and told her V5 was rude and would not stop going into her room. R1 would not make something up. V8 said V5 is just unkind to some of the residents. V5 intentionally agitates R3 also. On 9/20/22 at 12:05 PM, V6 (CNA) said on 9/9/22, R1 and V5 had an argument in the dining room at supper. V6 said she witnessed part of it. V5 asked R1 in front of her tablemates why she's telling people she is mean to her. R1 screamed at V5 and told her to go away and leave her alone. After supper, R1 and R4's call light was on. V6 said she went into their room and was talking to R1. V5 "came in behind me". R1 began screaming and told V5 to get out. V5 told R1 "to shut the f**k up". R1 asked V5 what she had just said and V5 said "shut up". V5 then pushed R1's "walker into her so hard R1 could have fallen. V5 told R1 to back the f**k up and stay away. It could have been bad. Luckily, R1 was able to catch herself". V5 then called R1 a "b***h and fat a**". My jaw dropped. "I was assigned to R1's hall and V5 was assigned to an adjacent set of rooms. V5 goes over there (R1 & R4's room) just to start trouble. R1 had told V5 a number of times to stay away from her. R4 said she didn't want her in there either. V9 called V1 (Administrator) and we told her everything. The second incident on the 16th (later corrected to the 15th), V5 was told	S9999		

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S9999	Continued From page 5 "plenty of times not to go into R1's room. I wasn't in the room that time. R1's call light came on and V5 asked me to answer it because she said I think the light is on because of me. V5 asked me to go into R1's room and turn the call light off. I told V5 no and V7 (LPN) went into R1's room. V6 said yes, "I observed V5 physically and verbally abuse R1. V5 continued to intentionally annoy R1, and she used R4 as an excuse to enter the room." On 9/20/22 at 2:37 PM, V9 (LPN) said she spoke to R1 after she heard the screaming in the room around 7:30 PM. V9 said R1 told her she had a disagreement with V5.V9 said V6 didn't report the incident details to her until 11:00 PM. V9 said V6 notified her that V5 physically and verbally abused R1. V9 said she notified V1 by telephone of the incident the same evening and V1 told her she'd deal with it in the morning. On 9/20/22 at 1:53 PM, R13 said she sits at R1's table for meals and saw R1 and V5 shouting at each other (on 9/9/22). R13 said I don't know who started it or what caused it. It made me uneasy because of course it's not acceptable for staff to be yelling at the residents. V5 was mad and yelling at R1. It looked like V5 was going to be violent and V5 was intimidating R1. On 9/20/22 at 2:03 PM, R15 said she sits at the table with R1 for meals. R15 said I don't know what R1 and V5 were arguing about (9/9/22) but V5 has a problem with her attitude. I've had problems with her. I told her to "cool it" once and she told me to cool it, right back. On 9/20/22 at 10:19 AM, V1 said she did not report the allegation to the State Agency, but she did investigate it.	S9999		

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S9999	Continued From page 6 On 9/20/22 at 2:45 PM, V1 said on 9/9/22 around 11:30 PM-12:00 AM she was notified by V6 or V9 about the incident between V5 and R1. "I didn't think it was abuse. That's why it wasn't reported."V1 (Administrator) said if a resident doesn't want a CNA in their room, the CNA can be reassigned or the CNA can bring a witness with them in the room. V1 (Administrator) said I didn't see it as abuse. It's important to do a thorough investigation to keep the residents safe and make sure everything is taken care of. It's important to get everyone's story and keep the perpetrator away from the residents. On 9/20/22 at 2:37 PM, V9 (LPN) said on 9/9/22 I was sitting at the nurses' station and heard R1 screaming. I didn't go see what was going on. On 9/9/22 at around 11:00 PM, V6 (CNA) told me V5 called R1 a "stupid b**ch" and pushed R1's walker almost knocking R1 down. I spoke to R1 around 7:30 PM that night. R1 said she didn't want V5 in her room. V5 did go back into R1's room later. Then I told her (V5) to stay out. Around 8:30-8:45 PM, V5 told me she didn't understand why R1 was being such a b**ch. V5 can be "crass" to the residents. I called V1 (Administrator) to report the incident and V6 spoke to her also. V1 said she'd deal with it in the morning. On 9/20/22 at 3:15 PM, R4 said "I was dumbfounded as to why V5 was being exceptionally nice to me. We didn't have a special relationship. I didn't know why all of a sudden, she was being so "gushy" with me. I could see this thing escalating and it scares me. V5 doesn't like anyone questioning what she does." R4 said V1 talked to her about an incident that happened on 9/9/22. V5 (Certified Nursing Assistant/CNA)	S9999		

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S9999	Continued From page 7 called R1 (R4's roommate) a fat a** and pushed her walker into her almost causing R1 to fall. V5 also kept coming into the room after being told to leave and to stay out. R4 said V1 "kept defending V5 regardless of what I said. V1 already had her mind made up. I told V1 that I saw it happen". On 9/20/22 at 3:20 PM, R1 said it was all swept under the rug. It's like nothing ever happened. R1 said R13-15 sit at the dining room table with her and witnessed V5 yelling at her on 9/9/22. R1 said it started in the dining room that evening. V5 is rude and ignorant to me all the time. V5 came up to me in front of my tablemates and said I hear you were telling people I was rude to you. And I said Well, you were. She (V5) finally left after I raised my voice. It all just escalated from there. "I fear for my life if she loses her job. Like a postal worker, she'd come back and shoot me. I don't want to get anyone hurt. I'd try to fight her. I'd lose but I won't be silent. She (V5) scares me, and I can't do anything about it". The facility's abuse investigation of the incident on 9/9/22 showed V1 (Administrator) told V5 to avoid going into R1's room. The facility's 9/9/22 and 9/15/22 evening shift staff assignment showed V5 was not assigned to R1's area. V5's time report showed V5 left the facility at 9:40 PM on 9/9/22. The facility's investigation report to the 9/9/22 incident does not include the day, time, location, the specific allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence or notation of or lack of resident injury. It does not indicate what the	S9999		

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S9999	Continued From page 8 allegation being investigated was or whether the allegation was substantiated or not. This report does not include any information on R1 including age, diagnosis and mental status. The investigation showed R1, R4, and V5 as the only person interviewed. The facility's Illinois Department of Public Health reported incidents do not include the 9/9/22 or 9/15/22 incidents. Two hours after V1 printed out the abuse investigation for this surveyor, four resident interview papers were provided. Two of the papers had R8's name at the top and were dated 9/10/22. Each of the papers marked "R8" had two different comments typed out. An interview paper with R9's name on it was dated 9/10/22. There was no current or discharged resident by this name in their system. The fourth interview form with R10's name and dated 9/10/22 had a comment typed on it. All four of the interview papers were signed by V3 (Resident Manager.) On 9/20/22 at 1:38 PM, R8 said V3 was just in here before lunch today interviewing me about staff and abuse. On 9/20/22 at 1:45 PM, R10 said V3 wanted to know about this too and talked to me today about it. The facility's investigation report to the incident of 9/15/22 (dated 9/10/22) showed only R1, R4 and V5 were interviewed. This investigation showed R1 stated R1 screamed at V5 to get out of her room, but she kept coming back 8-10 times. R1 requested V1 question V6 (Certified Nursing Assistant/CNA) about the incident. There was no evidence V6 (witnessed the abuse) and V9 (person abuse was reported to) were interviewed by the facility. There was no evidence any	S9999		

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S9999	Continued From page 9	S9999		

employees other than V5 were interviewed. The facility map showed R8 and R10's room are not adjacent to or across from R1 and R4's room. No residents in rooms adjacent to or across from R1's room was interviewed. None of the residents who sit at the dining table with R1were interviewed by the facility. No employees other than the alleged perpetrator were interviewed for the 9/9/22 incident.

The facility's investigation report to the incident of 9/15/22 (dated 9/16/22) showed only R1, R4, V5, and V7 were interviewed.

The 9/10 and 9/16/22 investigations were presented as one continuing document. There are no dates and times to the incident or interviews in the report. There is no indication what allegations were being investigated and whether the allegation was substantiated or not. The investigation does not include any resident demographic or medical information.

The facility's 1/22 Abuse Prevention Program showed this assumes that all instances of abuse of residents cause physical harm or pain or mental anguish. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend or disability. Mental abuse includes but is not limited to humiliation, harassment, threats of punishment or deprivation.
The facility's 1/22 Abuse Prevention Program

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showed the facility affirms the right of residents to be free from abuse. The facility therefore prohibits abuse. The purpose of the policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse of residents. This will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse; implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment and making the necessary changes to prevent future occurrences; filing accurate and timely investigative reports. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Employees are required to report any incident, allegation or suspicion of potential abuse they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse. Any incident that does not result in serious bodily injury shall be reported within 24 hours to the Illinois Department of Public Health. The facility will take steps to prevent potential abuse while the investigation is underway. Employees of this facility who have been accused of abuse will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have

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S9999	Continued From page 11 been reviewed by the administrator and it is determined that any allegation of abuse is unsubstantiated. All incidents will be documented whether abuse was alleged or suspected. The appointed investigator will at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Residents to whom the accused has regularly provided car, and employees with whom the accused has regularly worked will be interviewed. The final investigation report shall contain the following: name, age, diagnosis and mental status of the resident allegedly abused; the original allegation (note day, time, location, the specific allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries); facts determined during the process of the investigation, review of medical record and interview of witnesses; conclusion of the investigation based on known facts. The facility's 1/22 Abuse Prevention Policy showed when an allegation of abuse has been made the Administrator, or designee shall notify the Department of Public Health's regional office immediately by telephone or fax. "B"	S9999		