Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: ______ B. WING ______	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

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S 000	Initial Comments Complaint Investigation: #2223059/IL145975	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of 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. (Section 3-610(a) of the Act) 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. (Section 3-611 of the Act)	S9999		

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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.

These requirements are not met as evidenced by:

A. Based on observation, interview, and record review, the facility failed to prevent mental, verbal, and physical abuse from a Registered Nurse (V4) to eight of nine residents (R1, R2, R4, R5, R6, R7, R8, R9) reviewed for abuse in the sample of nine. These failures resulted in R1, R2, R4, R5, R6, R7, R8 and R9 having increased on-going feelings of anxiety, crying, and fearfulness, R4 and R5 sustaining physical abuse, and R7 sustaining bullying/disparaging comments regarding her disease.

B. Based on interview and record review, the facility failed to immediately remove the alleged perpetrator (V4, Registered Nurse) after allegations of verbal, physical, and mental abuse were made, thoroughly investigate these allegations of abuse by (V4) and failed to report these allegations to the State agency for eight of nine residents (R1, R2, R4, R5, R6, R7, R8 and R9) reviewed for abuse in the sample of nine. These failures resulted in V4 remaining in the facility and working directly with R1, R2, R4, R5, R6, R7, R8, and R9 which resulted in these residents suffering continual abuse, fear, retaliation, and bullying from V4. These failures have the potential to affect all 90 residing within the facility.

C. Based on observation, interview, and record review, the Administrator (V1) and Director of Nursing (V2) failed to immediately act upon and

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follow-up on numerous resident allegations alleging physical, verbal, and mental abuse sustained from Registered Nurse (V4) for eight of nine residents (R1, R2, R4, R5, R6, R7, R8, R9) reviewed for abuse in the sample of nine. These failures resulted in R1, R2, R4, R5, R6, R7, R8, and R9 living in on-going fear and retaliation of V4 in their own home. These failures had the potential to affect all 90 residents within the facility.

A. Findings include:

The facility's Abuse and Neglect Policy revised on July 2017 documents, "It is the policy of (the facility) to provide each resident with an environment free from abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of resident property, exploitation and physical or chemical restraint not required to treat the resident's symptoms, as defined below. The "facility" shall follow the procedure for the reporting and investigation of alleged resident abuse and neglect as outlined below, and in accordance with Skilled Nursing and Intermediate Care Facilities Code. "Abuse" refers to the willful infliction of injury, reasonable confinement, intimidation, punishment with resulting physical harm, pain, or mental anguish. Deprivation by an individual, including a caretaker, of goods or services which are necessary to attain or maintain physical, mental, and psychosocial well-being is also defined as abuse. Instances of abuse, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. "Mental Abuse" includes, but is not limited to, humiliation, harassment, threats of

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S9999	Continued From page 4 punishment or deprivation. "Physical Abuse" includes, but is not limited to, hitting, pinching, slapping, kicking, and controlling behavior through corporal punishment, this also includes resident to resident physical contact in the dementia unit." An Employee Warning Report dated 4/21/21 and signed by V25/Human Resources, documents, Employee name as (V4/Registered Nurse), Type of warning as Final Warning, Type of Offense as Violation of company policies. Description of Violation: "We continue to receive multiple complaints from residents and staff that you are rude to residents, yelling and cursing at them. We also receive complaints from staff that constitute as bullying and intimidation. It was also found that (V4) trained a staff member that if a resident is not allergic to Benadryl, that you can give it to them to help them sleep. This is a Category 2 Offense page 24 of your employee handbook #18, Discourtesy to the residents, residents' family, or fellow employees. Category 2 offenses should require disciplinary action but may not in all incidents result in immediate discharge in the absence of mitigating circumstances. This is also a Category 1 offense page 23 of your employee handbook #28 Threatening, intimidating, or coercing fellow employee, resident, visitors, or other people affected with (the facility). Category 1 offenses are most serious and subject an employee to immediate discharge in the absence of mitigating circumstances. Consequences of Further Violations: Follow (the facility's) policies and procedures. Any further violations of this policy will result in termination from employment depending on the offense." This warning was signed by V4 on 4/21/21. This warning also has documented that V2 (Director of Nursing) was	S9999		

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S9999	Continued From page 5 present. V4's Training Transcript documents V4 was in-serviced on Abuse and Neglect, Types of Abuse, and Preventing, Reporting, and Recognizing Abuse 3-4-16, 6-23-16, 7-13-17, 7-9-18, 8-7-19, 8-13-19, 6-15-21, and 4-10-22. 1. R1's MDS (Minimum Data Set) Assessment dated 1/31/22 documents R1 is cognitively intact. R1's POS (Physician Order Sheet) dated 4/20/22, documents R1 has diagnoses of Altered Mental Status and Major Depressive Disorder. On 4-20-22 at 9:45 AM R1 was sitting in her recliner in her room. R1 was alert and oriented to time, place, and name. R1 had tears in her eyes and R1 stated, "A couple weeks ago in the middle of the night around 2:30 AM, I was sleeping in my recliner with the television on. (V4, Registered Nurse) came into my room, ripped the covers off of me, and told me 'Get up. You are going to the bathroom.' I told her that I did not have to go to the bathroom. (V4) said, 'Yes, you are' and made me go to the bathroom. I looked at (V4) and said, 'Why are you so mean.' I do not know why (V4) was being so hateful to me. (V4) told me to shut my television off and go to bed. I did not want to go to bed. I feel like I should have the right to stay up and watch television. I take myself to the bathroom, so I do not know why (V4) felt the need to rip my covers off and make me go. I do not think (V4) likes herself very much. I was crying and (V4) told me to, 'Shut up.' I have told everybody about this and do not like that (V4) still takes care of me. I feel scared when she is on duty. (V4) is nothing but a bully. I can hear her out in the hallway yelling at other residents at times. She is just like Nurse Ratchet."	S9999		

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On 4-20-22 at 9:35 AM, V26 (LPN/Licensed Practical Nurse) stated, "About a week or two ago, (R1) told me that (V4) had went into her room in the middle of the night, jerked her covers off of her, and told (R1) to get the hell up and out of the chair. I reported this immediately to (V27/Social Services). (R1) continued to be very mad that day and would say, 'I am not going to let that b***h (V4) talk to me that way.' I have had a lot of residents complain in the past and have been told that if it is not in writing, it didn't happen. (R9) is very scared of (V4) and tells me that all the time. Also, I know there was an abuse allegation turned into (V2/Director of Nursing) regarding (V4) and (R4) in the past. I am not sure what the allegation regarding (R4) was about."

On 4-20-22 at 3:26 PM V15 (R1's Family Member) stated, "(R1) called me two weeks ago on a Thursday and told me (V4, Registered Nurse) came into her room, jerked the covers off of her, and made her go the restroom and then to bed. (R1) said (V4) was mean to her. I have cameras in her room, but that night they were unplugged for some reason. (R1) has never complained or made accusations about staff at the facility before. (R1) has been really upset. (R1) has called me at work at least three to four times a day since this incident and has had very bad anxiety. I have talked to (V2/Director of Nursing) about (R1's) accusations."

2. R2's MDS (Minimum Data Set) Assessment dated 4/6/22, documents R2 has moderately impaired cognition.

R2's POS (Physician Order Sheet) dated 4/20/22, documents R2 has a diagnosis of Major

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Depressive Disorder.

On 4-20-22 at 12:45 PM, R2 was sitting in his wheelchair. R2 stated, "There is a nurse on third shift. I do not know her name. She has blonde hair and has worked here awhile. She is hateful and yells at us (the residents). She has yelled at me a couple times before and I did not like it."

On 4/21/22 at 2:24 PM, V18 (CNA/Certified Nursing Assistant) stated, "(R2) refused his shower because he was in too much pain." (V4, Registered Nurse) came in his room and said "You (R2) wanted out of your room, now get up and take a shower." V18 then stated, "I stepped in and asked (R2) if he just wanted a bed bath and (R2) said, 'Yes.' I then gave him a bed bath and (V4) was mad at me. (V4) was taken off the floor for a while and moved to another hall but then put back on the 400-hall."

3. R4's MDS Assessment dated 4/13/22, documents R4 has moderately impaired cognition.

R4's POS dated 4/20/22, documents, R4 has Major Depressive Disorder.

R4's current plan of care documents, "Inappropriate Behavior, (R4) has exhibited inappropriate, rude, sexual behaviors and fondling self. Fondling or pleasuring self a total of three times during the quarter." Interventions include: R4 to masturbate as long as he does it in his room where others cannot see. Staff needs to knock prior to entering if he is masturbating return later. When R4 is in the common area and is being inappropriate, verbally or pleasuring himself, quietly caution him that he is in the common area, and it's inappropriate in the

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common area around staff and peers.

V5's (Service Attendant) undated Written Statement documents, "(R4) was sitting in the chair at the nurse's station. (R4) was trying to get our attention by pleasuring himself. (V4, Registered Nurse) told (R4) to stop. (R4) continued on laughing, thinking it was funny. (V4) rushed over there and grabbed (R4) by the penis and told (R4), 'If you don't stop that, I am ongoing to rip that thing off.' (R4) screamed because she (V4) grabbed (R4) so hard. (V4) continued to yell at him for the rest of the night."

On 4-20-22 at 11:45 AM R4 stated, "I am always getting yelled at by (V4) at night. (V4) is very mean!"

On 4-20-22 at 10:45 AM V28 (CNA) stated, "(V4, Registered Nurse) is very disrespectful to the residents and yells at them. I personally have heard (V4) yell at (R4). (R4) will yell, 'hey, hey, hey.' (V4) yelled at him to stop or will take him to his room. (V4) made (R4) go to his room. I have heard that (V5, Service Attendant) witnessed (V4) slap (R4) before."

On 4-20-22 at 1:00 PM V1 (Administrator) stated, "I got a call from V11 (President of the Board) on Monday (4-18-22) informing me that she had got a report of (V4) grabbing (R4's) 'crotch' and telling (R4) she was going to break it off about a month ago that was witnessed by (V5/Service Attendant). I gave this to (V25/Human Resources) on Tuesday (4-19-22) to look into. I guess a staff member grabbing a man's penis could be considered abuse. I also have received an email in January 2022 from (V11) regarding multiple resident concerns regarding (V4)."

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On 4-20-22 at 11:25 AM V7 (Nurse Resource Coordinator) stated, "A lot of residents do not like (V4). (V4) comes off as abrasive. One night in March 2022, (V5/Service Attendant) called me and told me that (V4) grabbed (R4's) penis and told (R4) that if he doesn't quit masturbating, she (V4) was going to break it off."

On 4-20-22 at 1:00 PM V5 (Service Attendant) stated, "I was sitting at the nurse's station on (3-9-22) around 6:30 PM and (R4) was masturbating in the little room connected to the nursing area. (V4, Registered Nurse) went up to (R4), grabbed (R4) by the penis, and screamed at (R4), 'If you don't stop that I am going to rip that thing off.' (R4) had his penis outside of his pants. Later that night, around 8:30 PM, (R4's) door to his room was closed and I could hear (V4) yelling at (R4), 'You son of a b***h.' I then heard a slap and heard (R4) yell back at (V4), 'ouch.' I was too scared to go in (R4's) room. I am scared of what (V4) might have done to me."

4. R5's MDS Assessment dated 2/1/22, documents R5 is cognitively intact.

R5's Physician's Orders dated 1-27-22 documents, "No bathing."

R5's Face Sheet/Census Report documents R5 was admitted to the facility on 12-22-21 and discharged home on 1-30-22. This same Face Sheet/Census Report documents R5 is responsible for herself.

V11's (President of the Board of Directors) Email (Electronic Mail) dated 1-17-22 and sent to V1 (Administrator) and V2 (Director of Nursing/DON) documents, "I spoke to (V1) regarding a phone call I received yesterday from (R5) and would like

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S9999	Continued From page 10 to provide you both with the details of that conversation. I don't know how much detail was provided in her formal grievance. (R5) is someone I know personally through another organization. (R5) is recovering from surgery at (the facility). I am confident in her mental faculties. Some of what (R5) shared with me is information that she has heard, so I know it can be difficult to sort through information that is not first-hand. Her specific grievance was with nurse (V4, Registered Nurse) failing to follow (R5's) doctor's orders. (R5) was advised that she should have absolutely no showers. Only sponge baths due to the need to keep her foot dry to promote scabbing. When (V4) told (R5) it was time for a shower, (R5) relayed this information to (V4) and was told (by V4) that she, 'Knew how to do her job' and that she could give her a shower without getting her foot wet. (R5) refused and felt she was treated disrespectfully as a result. I am not sure that this additional information was included in (R5's) formal grievance but she felt it needed to be shared with me. (R5) personally witnessed an incident where (V4) was openly mocking a resident (R7) at mealtime. (R5) says (R7) has Dementia or limited mental abilities and has a repetitive verbal tick where she says 'the-the-the' frequently. (R5) witnessed (V4) mock and repeat this tick to (R7) and to other staff in the lunchroom. Other incidents that (R5) didn't witness firsthand was (V4) had told a male resident (R2) that everybody hated him, and nobody wanted him there. (R5) heard that this male resident was going around to other residents in tears, asking if it was true that everyone hated him. (R5) also heard from (R6) that (V4) dragged (R6) out of her armchair at night onto the floor and stomped on her stomach. This would of course be a very serious incident if true. (R5) feels that other staff and residents are	S9999		

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fearful of (V4) and concerned about retribution if they were to report her. (R5) feels certain staff have quit as a result of (V4's) presence. (R5) has been advised by other residents (and staff, as I understand it) to watch her medicines very closely at night because some people are truly fearful that (V4) would harm them. I feel it is very important that we address this phone call in our executive meeting and that we move forward with investigation into (V4's) conduct and/or termination."

V9's (Social Service Director) Email (Electronic Mail) dated 12-29-21 at 3:13 PM and sent to (V2/Director of Nursing) documents, "Hi (V2). I spent a long time with (R5). I have attached (R5's) statement. All of (R5's) concerns show unprofessionalism by (V4), but I feel the one with (R7) in the (dining room) actually needs to be treated as abuse. I left a message on (V1's) voice mail to be official. Met with (R5) today (12-29-21) to speak with her about concerns with (V4). (R5) explained to me (V9) she had gone to see the orthopedic doctor on Tuesday. He removed (R5's) cast and gave her a boot. (R5) said she received instruction that boot was to remain on at all times and she was not to get leg/dressing wet. (R5) said he specifically told her no showers and she was to only have sponge baths for the time being. (R5) said (V4) came into her room last night at bedtime and said, 'We are taking a shower.' (R5) told (V4) 'no' because of doctor's instructions. (R5) says that (V4) replied that she was a professional and knew how to give a shower without getting her leg wet. (R5) refused again and said that (V4) then told (R5) it was in her 'directives' that she was to take a shower and said (V4) was calling (R5) a 'liar.' (R5) voiced being upset that (V4) was rude and not listening to what (R5) said the doctor told her

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and felt (V4) was trying to force her to do something she knew wasn't right and which also went against her doctor's orders. (R5) says there have been other issues with (V4) that have upset her, and one is (V4) accused her of not wearing a foam boot one day. (R5) explained that she had removed it when she put the call light on because she figured it would save staff time and trouble in getting her to the bathroom. Staff had told (R5) that (V4) had told them that she was 'refusing' to wear a foam boot. (R5) says, 'I am upset that a nurse would go out of their way to lie about me.' (R5) also reports that (V4) was mocking another resident (R7) repeatedly in the unit dining room and laughing about it. (R5) says (R7) tends to repeat 'the, the, the, there' repeatedly. (R5) said (V4) came into the dining room and told (R7) to stop because she needed to eat and then began making the same sounds (as R7) and laughing. (R5) says (V4) did this several times while walking around the dining room. (R5) said this made her feel very uncomfortable and felt it was cruel and unnecessary."

On 4-20-22 at 12:30 PM, R5 stated, "I lived at the facility in December 2021 for therapy after having three surgeries. I was not supposed to get my foot wet and was given orders to get a sponge bath only. (V4) told me I was liar, and she was a professional and knew how to give me a shower without getting my foot wet. I am 78 years old and told (V4) that I am not a liar, I would not be taking a shower, and I would be reporting her to my doctor's office. I called my doctor's office the next day and the doctor was very upset. The doctor called the facility the next day and told them that I 'am not' to have shower. (V4) also accused me of not wearing my foam purple boot as ordered. That same night around 11:00 PM, (V4) came into my room and said, 'What are you

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still doing up! You need to turn the television off and go to sleep.' I refused. I also witnessed (V4) mocking (R7) in the dining room. (R7) repeats, 'the, the, the, there' repeatedly and (V4) kept mocking (R7). (V4) was just bullying (R7). I would talk back to (V4) and not put up with her rudeness. The CNAs would tell me to watch my back. I was worried every night when I lived there that (V4) would do something bad to me. I asked that (V4) not take care of me, but she still continued to take care of me. I was worried that she would try to kill me by overmedicating me. I also watched (V4) yell at (R4) in the dining room and told (R4) that she hated him. I have reported all of this to (V9, Social Service Director). (V4) is very hateful and should not be a nurse."

On 4-20-22 at 2:25 PM V9 (Social Service Director) stated, "I met with (R5) on 12-29-21 to talk to her about concerns she has with (V4). (R5) did not like how (V4) was treating her. (R5) said (R5) told (V4) that she was not taking a shower due to doctor's orders, and that she was to only have a sponge bath. (R5) said that (V4) called her a 'liar' and said (V4) tried to force (R5) to take a shower and was telling (R5) she refused to wear her foam boot. (R5) was very upset and felt like (V4) was very rude. (R5) also told me that she saw (V4) mocking another resident (R7) repeatedly in the dining room and laughing about it. (R7) tends to repeat, 'the, the, the, the, there' repeatedly and (R5) said (V4) kept making the same sounds as (R7) and laughing about it. (R5) said this made her feel very uncomfortable and felt it was cruel and unnecessary. I let both (V1) and (V2) know that I felt like these allegations need to be treated as abuse."

5. R6's MDS Assessment dated 3/3/21 documents R6 is cognitively intact and ambulates

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in her room with staff assistance of one.

R6's MDS Assessment dated 3/3/22, documents R6 is cognitively intact and never ambulates even with staff assistance.

R6's progress notes dated 2/24/21, documents, R6 was being moved to another unit (100) due to behaviors and accusations R6 made of staff.

On 4-21-22 at 9:45 AM, R6 was sitting in her recliner in her room. R6 stated, "A while ago (2-24-21), (V4, Registered Nurse), the nurse, jerked me out of my chair, stomped on my feet, and punched me in the stomach. I told (V4) my feet were bleeding and (V4) said 'good.' (V4) then swung me around and threw me on my bed. I am lucky (V4) didn't throw me through the window. I feared for my life. (V4) was always mean to me and would cuss me out. I haven't been able to walk since (V4) stomped on my feet."

On 4-21-22 at 9:30 AM, V12 (R6's Power of Attorney) stated, "About a year ago in February 2021 when (R6) lived on the fourth floor (R6) had told me that (V4) had beaten her and stomped on her feet. I reported this to Social Services (V9) and (V2/Director of Nursing). (V2) made the decision to move (R6) down to the first floor so (V4) would no longer care for (R6). I know (V4) did take care of (R6) after that a couple of nights, even though (V2) said she would not let (V4) take care of (R6). I think because of staffing shortages (V4) was allowed to work with (R6). (R6) is still scared and upset with (V4). Just yesterday, (R6) told her urologist that she was beat up and yelled at by (V4). (R6) has refused to bear weight or walk since this allegation. (R6) is very smart and would know if somebody is

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abusing her. (R6) is truthful and has never made any false allegations in the past. This nurse (V4) has really caused (R6) a lot of suffering."

On 4/21/22 at 10:25 am., V13 (RN/Registered Nurse) stated, "(R6) told me that (V4) hit her and stomped on her foot and that was why she was moved from 400-hall to 100-hall."

On 4/21/22 at 10:40 am., V16 (CNA/Certified Nursing Assistant) stated, "(R6) told me multiple times (V4) ran over (R6's) feet several times with a wheelchair and would beat her up."

On 4/21/22 at 10:10 am., V14 (CNA) stated, "When (R6) moved to 100-hall around February 2021, (R6) complained about (V4) being mean to (R6) frequently. (R6) said that (V4) stomped on her feet and (R6) would give me notes written on menu papers about the accusations of (V4). (R6) also told me (V4) told (R6) she needed to get in her bed and get to sleep. (R6) complained to me later that (V4) was working on 100-hall and was not supposed to, so I informed (V2)."

6. R7's MDS Assessment dated, 3/30/22, documents R5 has moderately impaired cognition.

R7's POS dated 4/20/22, documents R7 has diagnoses of Vascular Dementia without Behavioral Disturbance, Dementia with Lewy Bodies, and Cognitive Communication Deficit

R7's current plan of care documents, "(R7) has an alteration in neurological status due to Dementia, Repetitive verbalizations. (R7) has impaired recall and decision-making skills secondary to Lewy Body Dementia. At times, (R7) has chanted "Oh God" or other

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verbalizations repeatedly."

On 4-20-22 at 11:45 AM, R9 was sitting in her room. R9 stated, "(V4) has mocked a resident (R7) in the dining room. I felt really sorry for (R7). (R7) cannot help her disease."

7. R8's 3-31-21 MDS Assessment documents R8 was cognitively intact.

V23's (CNA) written statement dated 3/30/21 and signed by V23, documents, "I got the resident (R8) up this morning, and she was happy. I left the room to answer a call light and staff (V24/CNA) came to me saying (R8) was crying face red and stated (V4) yelled at her and was being mean to her. At that time (V27/Social Service) was walking by. I asked (V27) to talk to (R8) and when (V27) came in, I left the room."

On 4-20-22 at 9:55 AM, R8 was sitting in her room. R8 stated, "I am not going to tell you anything about who has been mean to me. If I do not tell, then I do not get in trouble. If I told you what she had done to me, she would just make my life worse."

8. R9's MDS Assessment dated 3-16-22 documents R9 is cognitively intact.

V22's (CNA) written statement dated 3/30/21 and signed by V22, documents, "(R9) has made numerous complaints about (V4, Registered Nurse) and the way she treats her and talks to her. (R9) said that she is in her right mind and that she would never talk to someone the way that (V4) talks to the residents. (R9) said (R8) has cried to (R9) numerous times because (R8) says (V4) is rough and mean with her. This is an ongoing thing, and it's to the point to where the

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majority of the residents have complained about (V4) or are scared of (V4)."

V24's (CNA) written statement dated 3/30/21 and signed by V24, documents, "I went to get (R9) up for a shower, and she asked me what nurse was on shift tonight. I told (R9) (V19/RN) was the nurse tonight. (R9) said, 'Oh thank you I was scared it was (V4).' (V4) came in here and was rude and told me to take my pills in pudding. I got choked up on them and spit it out. (V4) is never nice when she comes in. (R9) also stated that she was very scared of (V4)."

On 4-20-22 at 11:45 AM, R9 was sitting in her room. R9 stated, "I do not like to get anybody in trouble. (V4) is mean to me and a lot of other residents. (V4) yells at us a lot. I don't know if (V4) has a bad home life and she takes it out on us."

On 4-21-21 at 8:45 AM, V3 (Assistant Director of Nursing) stated, "I cannot find any documentation in (R1, R2, R4, R5, R6, R7, R8, and R9's) medical records regarding their allegations of abuse regarding (V4)."

On 4-20-22 at 1:05 PM, V8 (Registered Nurse) stated, "(V4, Registered Nurse) has been abusing residents for years. (R2) was crying one morning to me that (V4) told him nobody can stand (R2), and she (V4) hates him. (R2) was crying for days asking the staff if they like him. This happened several months ago. I submitted statements to (V2) and notified (V2) immediately. (V4) mocks (R7) in the dining room and I know (R6) had to be moved off of 400-hallway due to (R6) reporting that (V4) beat her up and yelled at her."

On 4-20-22 at 12:15 PM, V11 (President of Board

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of Directors) stated, "I have a friend that was a resident at the facility (R5). (R5) is now residing at home. On 1-17-22, I contacted (V1) and (V2) about concerns (R5) had reported to me. (R5) had concerns with a nurse (V4). (R5) also said (V4) was trying to force (R5) to take a shower, even though (R5) had a doctor's order to only take sponge bathes. (R5) felt like she was not treated or respected very well by (V4). (R5) also said she witnessed (V4) mocking a resident (R7) during meals that had a known 'tick.' (R5) also reported (V4) told a resident (R2) that everyone hated him and caused (R2) to have tears. On Monday (4-18-22), (R5) told me (R4) had been assaulted by (V4, Registered Nurse) and had been slapped by (V4)."

On 4/21/22 at 2:45 PM, V2 (DON/Director of Nursing) stated, "(V4) was taken off 400-hall for about six months due to many complaints from staff and residents on that hall." V2 stated she can't remember the residents but did provide the staff names (V19/RN, V20/CNA, V21/CNA) that had the complaints.

On 4-22-22 at 9:55 AM V19 (Registered Nurse) stated, "(R5) was scared of (V4) and said she was afraid (V4) would try to overdose her. When I first started there around December 2020, (V4, Registered Nurse) was orientating me. One night during this time around 7:00 PM to 9:00 PM, (R6) was weak and trying to sit down while she was walking. (V4) started yelling and cussing at her to keep going and made her walk the rest of the way to her chair. (R6) was angry and upset and was yelling back at (V4). (V4) was very verbally abusive to (R6). (R6) would get so upset with (V4) and tell me that (V4) "hates her." I know (R6) got so upset that (R6's) psychiatrist called the facility and said it would be in (R6's) best

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interest to not have to be around (V4) at all. (R6) was then moved from 400-hallway to 100-hallway and (V4) was not supposed to work with (R6). Later on, (V4) had so many complaints filed against her from residents on 400-hallway, that the supervisors decided to move her to 100-hallway for a few months. I thought that was ridiculous to just move (V4) to another hallway and let (R6) have to be cared for by (V4) again. (R2) was very friendly and always visit with me while I was passing my medications. Around November 2021, (R2) would tell me almost every night that I worked that he was afraid of (V4) and would thank me for working there. (R2) would say on the nights that (V4) would work with him, he would get yelled at by (V4). (R9) is a very sweet little old lady that would not cause any trouble with anybody. (R9) would tell me that she doesn't like (V4) and has heard (V4) 'belittling' (R7) in the dining room. (R9) would tell me that she was scared of (V4). (R8) would whisper to me that (V4) yells at her and to not tell anybody because it would get back to (V4). (R8) would say she was afraid of (V4) and would not tell my why. Every time I would call (V1) with concerns he would tell me, 'What do you want me to do about it?' I quit there because I could not take it anymore hearing the abuse that the residents were receiving from (V4, Registered Nurse) and nothing being done about it."

B. Findings include:

The facility's Abuse and Neglect Policy revised on July 2017 documents, "Identifying and Recognizing Signs and Symptoms of Abuse: 1.) The following are examples of actual abuse/neglect and signs and symptoms of abuse/neglect which should be promptly reported. This listing is not all-inclusive. Other signs and

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S9999	Continued From page 20 symptoms or actual abuse/neglect may be apparent. When in doubt, REPORT IT IMMEDIATELY. i. Signs of/Actual Physical Abuse: A.) Welts or Bruises; B.) Abrasions or lacerations; C.) Fractures, dislocations, or sprains of questionable origin; D.) Black eyes or broken teeth; E.) Sexually exploited, G.) Rape; H.) Excessive exposure to heat or cold; I.) Involuntary seclusion; J.) Multiple burns or human bites. ii. Signs of/Actual Physical Neglect A.) Malnutrition and dehydration (unexplained weight loss; B.) Poor hygiene; C.) Inappropriate clothing (soiled, tattered, poor fitting, lacking, inappropriate for season); D.) Decayed teeth; E.) Improper use/administration of medication; F.) Inadequate provision of care; G.) Caregiver indifferent to resident's personal care and needs; H.) Failure to provide privacy I.) Left alone but needs supervision. iii. Signs/Symptoms of psychological abuse/neglect; A.) Resident clings to abuser/caretaker; B.) Paranoia; C.) Depression; D.) Confusion; E.) Disorientation; F.) Withdrawal; G.) Inconsistent injury explanation; H.) Low self-esteem or self-worth; I.) Anger; and/or J.) Suicidal. VI. Abuse Investigations: All reports of resident abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the organization management. The administrator shall be notified immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator along with the (State agency), and adult protective services, if necessary. 1.) Should an incident or suspected incident of abuse, neglect, or injury of an unknown source be reported, the administrator,	S9999		

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S9999	Continued From page 21 or his/her designee, will appoint a member of management to investigate the alleged incident. 2.) The person in charge of the investigation will be provided a completed copy of the abuse report form, witness statement, and or information regarding the alleged incident. 3.) The individual conducting the investigation will, at a minimum: i. Review the resident's medical record to determine events leading up to the incident; ii. Interview the person(s) reporting the incident; iii. Interview any witnesses to the incident; iv. Interview the resident (as medically appropriate), v. Interview the resident's attending Physician to determine the resident's current mental status; vi. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; vii. Interview the resident's roommate, family members, and visitors; viii. Interview other resident's roommate, family members, and visitors; ix. Interview other residents to whom the accused employee provides care or services, and x. Review all events leading up to the alleged incident. 5.) Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports. 6.) While the investigation is being conducted, accused individual not employed by the facility will be denied unsupervised access to residents. Visits may only be made in designated areas approved by the administrator. 7.) Employees of the organization who have been accused of resident abuse shall be suspended from duty pending the results of the investigation which shall be reviewed by the Administrator. 8.) The individual in charge of the investigation will consult with the administrator on a daily basis concerning the progress/findings of the investigation. 9.) The administrator or designee shall keep the resident and his/her representative informed of the progress of the investigation. 10.)	S9999		

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The results of the investigation will be documented. 11.) A copy of the completed investigation shall be provided to the Administrator within five working days of the reported incident. 12.) The Administrator or designee shall inform the resident and his/her representative of the results of the investigation and corrective action taken within five days of the completion of the investigation. 13.) Should the investigation reveal that abuse occurred; the administrator or designee shall report such findings to the ombudsman, the state licensing agency, and others, as may be required by state or local laws immediately. 15.) Allegations of abuse are reported to the state survey agency immediately. The administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency within five days of the reported incident. VII. Protection of Resident During Abuse Investigations: 1.) During abuse investigations, residents will be protected from harm by the following measures: i. Employees accused of participating in the alleged abuse will be immediately suspended until the findings of the investigation have been reviewed by the administrator. VIII. Reporting Abuse: Facility Management, it is the responsibility of all employees, consultants, attending physicians, family members, etc., to immediately report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of unknown origin, and theft or misappropriation of resident property to the Administrator. 2.) Employees, consultants, and/or attending Physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately. 3.) The Administrator must be immediately notified of suspected abuse,

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S9999	Continued From page 23 allegations of abuse, or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator shall be contacted immediately. vi. The Resident's Attending Physician; and/or vii. The Facility Medical Director. 5.) Notices to the above agencies/individual may be submitted via United States mail, special carrier, facsimile, electronic mail, or by telephone. Such notices will include, as minimum: i. The name of the resident; ii. The number of the room in which the resident resides; iii. The type of abuse committed (i.e., verbal, physical, sexual, neglect, etc.): iv. The date and time the alleged incident occurred, v. The name(s) of all persons involved in the alleged incident, and. Vi. Describe immediate action taken by the organization. 7.) Any individual observing an incident of resident abuse or suspecting resident abuse must move resident from harm and immediately report such incident to the home Administrator. 9.) A completed copy of the abuse report and written statements from witness, if any, must be provided to the Administrator within 24 hours of the reporting of such incident. An immediate investigation shall be made and a copy of the findings of such investigation shall be provided to the Administrator within five working days of the reporting of such incident. 10.) When an incident of resident abuse is suspected or determined, such incident must be report to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy. State Agencies: To assure all serious bodily injuries and reasonably suspected crimes against a resident resulting in serious bodily injuries are reported to the (State Agency) by phone immediately, and all serious incidents and accidents, and allegations of abuse, including	S9999		

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injuries of unknown source, and reasonable suspicion of crime against a resident are reported to the (State Agency) in an appropriate fashion immediately with a final report sent to the department within five days."

The facility's Daily Census Sheet dated 4-20-22 documents 90 residents reside within the facility.

V22 (CNA/Certified Nursing Assistant) written statement dated 3/30/21 and signed by V22, documents, "(R9) has made numerous complaints about (V4) and the way she (V4) treats her and talks to her. (R9) said that she is in her right mind and that she would never talk to someone the way that (V4) talks to the residents. (R9) said (R8) has cried to (R9) numerous times because (R8) says (V4) is rough and mean with her. This is an ongoing thing and it's to the point to where the majority of the residents have complained about (V4) or are scared of (V4)."

An Employee Warning Report dated 4/21/21 and signed by V25/Human Resources, documents, Employee name as (V4, Registered Nurse), Type of warning as Final Warning, Type of Offense as Violation of company policies. Description of Violation: "We continue to receive multiple complaints from residents and staff that you are rude to residents, yelling and cursing at them. We also receive complaints from staff that constitute as bullying and intimidation. This is also a Category 1 offense page 23 of your employee handbook #28 Threatening, intimidating, or coercing fellow employee, resident, visitors, or other people affected with (the facility). Category 1 offenses are most serious and subject an employee to immediate discharge in the absence of mitigating circumstances. Consequences of Further Violations: Follow (the facility's) policies

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S9999	Continued From page 25 and procedures. Any further violations of this policy will result in termination from employment depending on the offense." This warning was signed by V4 on 4/21/21. This warning also has documented that V2 (Director of Nursing) was present. V11's (President of the Board of Directors) Email (Electronic Mail) dated 1-17-22 and sent to V1 (Administrator) and V2 (Director of Nursing/DON) documents, "I spoke to (V1) regarding a phone call I received yesterday from (R5) and would like to provide you both with the details of that conversation. (R5) personally witnessed an incident where (V4) was openly mocking a resident (R7) at mealtime. (R5) says (R7) has Dementia or limited mental abilities and has a repetitive verbal tick where she says, 'the-the-the' frequently. (R5) witnessed (V4) mock and repeat this tick to (R7) and to other staff in the lunchroom. Other incidents that (R5) didn't witness firsthand was (V4) had told a male resident (R2) that everybody hated him, and nobody wanted him there. (R5) heard that this male resident was going around to other residents in tears, asking if it was true that everyone hated him. (R5) also heard from (R6) that (V4) dragged (R6) out of her armchair at night onto the floor and stomped on her stomach. This would of course be a very serious incident if true. (R5) feels that other staff and residents are fearful of (V4) and concerned about retribution if they were to report her. (R5) feels certain staff have quit as a result of (V4's) presence. (R5) has been advised by other residents (and staff, as I understand it) to watch her medicines very closely at night because some people are truly fearful that (V4) would harm them. I feel it is very important that we address this phone call in our executive meeting and that we move forward with	S9999		

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investigation into (V4's) conduct and/or termination."

On 4-20-22 at 9:35 AM V26 (LPN/Licensed Practical Nurse) stated, "About a week or two ago, (R1) told me that (V4) had went into her room in the middle of the night, jerked her covers off of her, and told (R1) to get the hell up and out of the chair. I reported this immediately to (V27/Social Services). (R1) continued to be very mad that day and would say, 'I am not going to let that b***h (V4) talk to me that way.' I have had a lot of residents complain in the past and have been told that if it is not in writing, it didn't happen. (R9) is very scared of (V4) and tells me that all the time. I know there was an abuse allegation turned into (V2/Director of Nursing) regarding (V4) and another resident (R4) in the past."

On 4-20-22 at 11:25 AM V7 (Nurse Resource Coordinator) stated, "One night in March 2022, (V5/Service Attendant) called me and told me that (V4, Registered Nurse) grabbed (R4's) penis and told (R4) that if he doesn't quit masturbating, she (V4) was going to break it off. I did not report this allegation to (V1/Administrator). I wasn't thinking. I put a written statement in (V2's) office box about the allegation on Monday (March 14)."

On 4-20-22 at 1:00 PM V5 (Service Attendant) stated, "I was sitting at the nurse's station on (3-9-22) around 6:30 PM and (R4) was masturbating in the little room connected to the nursing area. (V4/RN) went up to (R4), grabbed (R4's) by the penis, and screamed at (R4), 'If you don't stop that I am going to rip that thing off.' (R4) had his penis outside of his pants. Later that night, around 8:30 PM, (R4's) door to his room was closed and I could hear (V4) yelling at (R4), 'You son of a b***h.' I then heard a slap and

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S9999	Continued From page 27 heard (R4) yell back at (V4), 'ouch.' I was too scared to go in (R4's) room. I am scared of what (V4) might have done to me. I did not report this to (V1/Administrator) or (V2/Director of Nursing). I called and reported this to (V7/Nurse Resource Coordinator) later that night. I did give (V2) a written statement later the next week." On 4-20-22 at 2:25 PM V9 (Social Service Director) stated, "I met with (R5) on 12-29-21 to talk to her about concerns she had with (V4). (R5) did not like how (V4) was treating her. (R5) said (R5) told (V4) that she was not taking a shower due to doctor's orders, and that she was to only have a sponge bath. (R5) said that (V4) called her a 'liar' and said (V4) tried to force (R5) to take a shower and was telling (R5) she refused to wear her foam boot. (R5) was very upset and felt like (V4) was very rude. (R5) also told me that she saw (V4) mocking another resident (R7) repeatedly in the dining room and laughing about it. (R7) tends to repeat 'the, the, the, the, there' repeatedly and (R5) said (V4) kept making the same sounds as (R7) and laughing about it. (R5) said this made her feel very uncomfortable and felt it was cruel and unnecessary. I reported this all in an email to (V2/Director of Nursing) and left a message on (V1's) voicemail regarding the allegations. I let both (V1) and (V2) know that I felt like these allegations need to be treated as abuse." On 4-20-22 at 1:05 PM V8 (Registered Nurse) stated, "(V4) has been abusing residents for years. (R2) was crying one morning to me that (V4) told him nobody can stand (R2), and she (V4) hates him. (R2) was crying for days asking the staff if they like him. This happened several months ago. I submitted statements to (V2) and notified (V2) immediately. (V4) mocks (R7) in the	S9999		

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dining room and I know (R6) had to be moved off of 400-hallway due to (R6) reporting that (V4) beat her up and yelled at her."

On 4-20-22 at 12:15 PM V11 (President of Board of Directors) stated, "On 1-17-22 I contacted (V1) and (V2) about concerns (R5) had reported to me. (R5) had concerns with a nurse (V4). (R5) also said (V4) was trying to force (R5) to take a shower, even though (R5) had a doctor's order to only take sponge bathes. (R5) felt like she was not treated or respected very well by (V4). (R5) also said she witnessed (V4) mocking a resident (R7) during meals that had a known 'tick.' (R5) also reported (V4) told a resident (R2) that everyone hated him and caused (R2) to have tears. On Monday (4-18-22), (R5) told me (R4) had been assaulted by (V4) and had been slapped by (V4). I notified (V1) by phone of this allegation immediately on Monday (4-18-22). I would have expected (V1) to have investigated all of these allegations as abuse."

On 4-21-22 at 9:45 AM, R6 was sitting in her recliner in her room. R6 stated, "A while ago (2-24-21), (V4, Registered Nurse), the nurse, jerked me out of my chair, stomped on my feet, and punched me in the stomach. I told (V4) my feet were bleeding and (V4) said 'good.' (V4) then swung me around and threw me on my bed. I am lucky (V4) didn't throw me through the window. I feared for my life. (V4) was always mean to me and would cuss me out. I haven't been able to walk since (V4) stomped on my feet."

On 4-21-22 at 9:30 AM, V12 (R6's Power of Attorney) stated, "About a year ago in February 2021 when (R6) lived on the fourth floor, (R6) had told me that (V4) had beaten her and stomped on

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her feet. I reported this to Social Services (V9) and (V2/Director of Nursing). (V2) made the decision to move (R6) down to the first floor so (V4) would no longer care for (R6). I know (V4) did take care of (R6) after that a couple of nights, even though (V2) said she would not let (V4) take care of (R6)."

On 4-21-22 at 10:20 AM, V27 (Social Worker) stated, "I have reported the allegation that (R1) made about (V4) to (V2). I have been notified of multiple resident allegations of verbal abuse from (V4) and have reported all of them to (V2). I have not documented any of these allegations in the resident's Social Service notes or progress notes. I know (R6) had made several allegations about (V4). I have not reported any of these allegations to (V1)."

On 4-22-22 at 9:55 AM V19 (Registered Nurse) stated, "(R5) was scared of (V4) and said she was afraid (V4) would try to overdose her. When I first started there around December 2020 (V4) was orientating me. One night during this time around 7:00 PM to 9:00 PM, (R6) was weak and trying to sit down while she was walking. (V4) started yelling and cussing at her to keep going and made her walk the rest of the way to her chair. (R6) was angry and upset and was yelling back at (V4). (V4) was very verbally abusive to (R6). (R6) would get so upset with (V4) and tell me that (V4) 'hates her.' I know (R6) got so upset that (R6's) psychiatrist called the facility and said it would be in (R6's) best interest to not have to be around (V4) at all. (R6) was then moved from 400-hallway to 100-hallway and (V4) was not supposed to work with (R6). Later on, (V4) had so many complaints filed against her from residents on 400-hallway, that the supervisors decided to move her to 100-hallway for a few

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months. I thought that was ridiculous to just move (V4) to another hallway and let (R6) have to be cared for by (V4) again. Around November 2021, (R2) would tell me almost every night that I worked that he was afraid of (V4) and would thank me for working there. (R2) would say on the nights that (V4) would work with him, he would get yelled at by (V4). (R9) is a very sweet little old lady that would not cause any trouble with anybody. (R9) would tell me that she doesn't like (V4) and has heard (V4) 'belittling' (R7) in the dining room. (R9) would tell me that she was scared of (V4). (R8) would whisper to me that (V4) yells at her and to not tell anybody because it would get back to (V4). (R8) would say she was afraid of (V4) and would not tell my why. I have reported all of these allegations to (V7/Nurse Coordinator) and (V7) would report them to (V2). I never notified (V1) of any of these allegations. Every time I would call (V1) with concerns he would tell me, 'What do you want me to do about it?' I did not even know that (V1) was the abuse coordinator."

On 4-20-22 at 12:15 PM, V11 (President of Board of Directors) stated, "(V1) has never gotten back to me with the outcome or what has been done regarding all of the resident's allegations of abuse from (V4). I thought (V1) would have taken care of it."

On 4-20-22 at 9:45 AM V1 (Administrator) stated, "I have had no staff to resident abuse allegations made to me in the last six months."

On 4-21-21 at 8:45 AM V3 (ADON/Assistant Director of Nursing) stated, "(R1, R2, R4, R5, R6, R7, R8, and R9's) allegations of abuse regarding (V4) have never been reported to the State, investigated, and (V4) has not been suspended

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pending investigation. None of these allegations have been documented in the resident's clinical records. (V1) was made aware of the allegations regarding (R1) and (R4). (V4) is able to work all floors with all residents."

On 4-22-22 at 9:30 AM (V2, Director of Nursing) stated, "I cannot find that an investigation was done regarding (R8 and R9's) allegations of abuse from (V4). I cannot find where (V4) has ever been suspended or removed from resident care for abuse allegations pending investigation."

On 4-20-22 at 1:00 PM V1 (Administrator) stated, "I got a call from V11 (President of the Board) on Monday (4-18-22) informing me that she had got a report of (V4) grabbing (R4's) 'crotch' and telling (R4) she was going to break it off about a month ago that was witnessed by (V5/Service Attendant). I did not report this or investigate this as abuse. I guess a staff member grabbing a man's penis could be considered abuse. (V4) has not been suspended because as of yesterday I did not feel like this allegation rose to the level of abuse. I also have received an email in January 2022 from (V11) regarding multiple resident concerns regarding (V4). I turned all of this over to (V2) and (V3/Assistant Director of Nursing/ADON) to investigate. I trusted that (V2) would do the reports to the State and the investigation. I did not have anything else to do with it once I turned it over to (V2) and (V3). I am the abuse coordinator. I do not recall any other allegations of abuse made to me about (V4) regarding (R1, R2, R4, R5, R6, R7, R8, or R9). (V4) has never been suspended pending an abuse investigation."

C. Findings include:

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S9999	Continued From page 32 The facility's Administrator/Chief Executive Officer Job Description Policy, revised 2/14/13, documents, "The primary purpose of your job position is to direct the day-to-day operations and functions of the facility in accordance with current Federal, State, and local laws, standards, guidelines, and regulations that govern the long-term care facility to assure that the highest degree of quality care can be provided to the resident at all times. For such purpose, and in dealing with all government regulatory agencies, you are "Administrator" of (the facility). Major Duties and Responsibilities: Assure that all employees, residents, visitors, and the general public follow established policies and procedure. Create and maintain an atmosphere of warmth, personal interest, and positive emphasis, as well as a calm environment throughout the facility. Personnel Functions: Recruit and select competent department directors, supervisors, consultants, and other auxiliary personnel. Consult the department directors concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services. Terminate employees when necessary, documenting and coordinating such actions with the Human Resources Director. Resident Rights: Ensure that resident's rights to fair and equitable treatment, self-determination, individually, privacy, property and civil rights, are well established and maintained at all times within the administration guidelines. Review residents' complaints and grievances and make written reports of action taken. Miscellaneous: Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Assure that each resident receives the necessary nursing, medical,	S9999		

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S9999	Continued From page 33 and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. Working conditions: Is involved with residents, family members, personnel, visitors, government agencies/personnel, etc., under all conditions/circumstances. Maintains a liaison with residents, their families, support personnel, etc., to assure that the residents' needs are continually met. Specific Requirements: Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines pertaining to long-term care administration." V1's Hiring Authorization Form documents V1 was hired as the Administrator of the facility on 12-27-2018. The facility's Director of Nursing Job Description Policy, Revised 3/2017, documents, "The primary purpose of your job description is to plan, organize, develop and direct the overall operation of the Nursing Department in accordance with current Federal, State, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care for our Residents is maintained at all times. Administrative Functions: Plan, develop, organize, implement, evaluate and direct the Nursing Department in accordance with current rules, regulations and guidelines that govern the long-term facility. Personnel Functions: Determine staffing needs for Nursing Department to assure the highest level of care attainable for our Residents. Review grievances and complaints made or filed by nursing personnel.	S9999		

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	IL6009302	A. BUILDING: ______ B. WING ______	C 04/28/2022

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Safety and Sanitation: Promote a safe environment for the Residents and staff. Resident Rights Functions: Ensure that all Nursing Services personnel are knowledgeable of the Residents' Rights and Responsibilities. Monitor Nursing Services to assure that all Residents are treated fairly and with kindness, dignity and respect. Coordinate and direct the Quality Assessment and Assurance program to enhance the quality of life for the Residents in accordance with current rules, regulations, and guidelines that govern the long-term care facility. Responsible for the identification, review, investigation, determination and necessary actions to be taken with Resident complaints and grievances."

V2's Personnel Action Change Form documents V2 was hired as the Director of Nursing on 3-15-2017.

The facility's Daily Census Sheet dated 4-20-22 documents 90 residents reside within the facility.

On 4-21-22 at 9:45 AM, R6 was sitting in her recliner in her room. R6 stated, "A while ago (2-24-21), (V4, Registered Nurse), the nurse, jerked me out of my chair, stomped on my feet, and punched me in the stomach. I told (V4) my feet were bleeding and (V4) said 'good.' (V4) then swung me around and threw me on my bed. I am lucky (V4) didn't throw me through the window. I feared for my life. (V4) was always mean to me and would cuss me out. I haven't been able to walk since (V4) stomped on my feet."

On 4-20-22 at 9:45 AM, R1 was sitting in her recliner in her room. R1 was alert and oriented to time, place, and name. R1 had tears in her eyes,

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S9999	Continued From page 35 and R1 stated, "A couple weeks ago in the middle of the night around 2:30 AM, I was sleeping in my recliner with the television on. (V4, Registered Nurse) came into my room, ripped the covers off of me, and told me, 'Get up. You are going to the bathroom.' I told her that I did not have to go to the bathroom. (V4) said yes you are and made me go to the bathroom. I looked at (V4) and said, 'Why are you so mean.' I do not know why (V4) was being so hateful to me. (V4) told me to shut my television off and go to bed. I did not want to go to bed. I was crying and (V4) told me to, 'Shut up.' I have told everybody about this and do not like that (V4) still takes care of me. I feel scared when she is on duty. (V4) is nothing but a bully. I can hear her out in the hallway yelling at other residents at times. She is just like Nurse Ratchet." V22's (CNA/Certified Nursing Assistant) written statement dated 3/30/21 and signed by V22, documents, "(R9) has made numerous complaints about (V4) and the way she treats her and talks to her. (R9) said that she is in her right mind and that she would never talk to someone the way that (V4) talks to the residents. (R9) said (R8) has cried to (R9) numerous times because (R8) says (V4) is rough and mean with her. This is an ongoing thing and it's to the point to where the majority of the residents have complained about (V4) or are scared of (V4)." An Employee Warning Report dated 4/21/21 and signed by V25/Human Resources, documents, Employee name as (V4), Type of warning as Final Warning, Type of Offense as Violation of company policies. Description of Violation: "We continue to receive multiple complaints from residents and staff that you are rude to residents, yelling and cursing at them. We also receive	S9999		

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complaints from staff that constitute as bullying and intimidation. This warning was signed by V4, Registered Nurse, on 4/21/21. This warning also has documented that V2 was present.

V11's (President of the Board of Directors) Email (Electronic Mail) dated 1-17-22 and sent to V1 (Administrator) and V2 (Director of Nursing/DON) documents, "(R5) says (R7) has Dementia or limited mental abilities and has a repetitive verbal tick where she says, 'the-the-the' frequently. (R5) witnessed (V4/Registered Nurse) mock and repeat this tick to (R7) and to other staff in the lunchroom. Other incidents that (R5) didn't witness firsthand was (V4) had told a male resident (R2) that everybody hated him, and nobody wanted him there. (R5) heard that this male resident was going around to other residents in tears, asking if it was true that everyone hated him. (R5) also heard from (R6) that (V4) dragged (R6) out of her armchair at night onto the floor and stomped on her stomach. This would of course be a very serious incident if true. (R5) feels that other staff and residents are fearful of (V4) and concerned about retribution if they were to report her. (R5) feels certain staff have quit as a result of (V4's) presence. (R5) has been advised by other residents (and staff, as I understand it) to watch her medicines very closely at night because some people are truly fearful that (V4) would harm them. I feel it is very important that we address this phone call in our executive meeting and that we move forward with investigation into (V4's) conduct and/or termination."

V4's Time and Attendance Report dated 2-4-22 through 4-19-22 documents V4 has worked full time hours within the facility.

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On 4-20-22 at 9:35 AM, V26 (LPN/Licensed Practical Nurse) stated R1, R4 and R9 have made abuse allegations regarding (V4) to her and she reported those allegations to V2 (Director of Nursing).

On 4-20-22 at 11:25 AM V7 (Nurse Resource Coordinator) stated, "One night in March 2022, (V5/Service Attendant) called me and told me that (V4, Registered Nurse) grabbed (R4's) penis and told (R4) that if he doesn't quit masturbating, she (V4) was going to break it off. I did not report this allegation to (V1/Administrator). I wasn't thinking. I put a written statement in (V2's) office box about the allegation on Monday (March 14)."

On 4-20-22 at 1:05 PM V8 (Registered Nurse) stated, "(V4) has been abusing residents for years. (R2) was crying one morning to me that (V4) told him nobody can stand (R2), and she (V4) hates him (R2). (R2) was crying for days asking the staff if they like him. This happened several months ago. I submitted statements to (V2) and notified (V2) immediately. (V4) mocks (R7) in the dining room and I know (R6) had to be moved off of 400-hallway due to (R6) reporting that (V4) beat her up and yelled at her."

On 4-20-22 at 12:15 PM, V11 (President of Board of Directors) stated, "I would have expected (V1, Administrator) to have investigated all of these allegations as abuse."

On 4-21-22 at 9:30 AM, V12 (R6's Power of Attorney) stated, "About a year ago in February 2021 when (R6) lived on the fourth floor, (R6) had told me that (V4) had beaten her and stomped on her feet. I reported this to Social Services (V9) and (V2/Director of Nursing). (V2) made the decision to move (R6) down to the first floor so

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(V4) would no longer care for (R6). I know (V4) did take care of (R6) after that a couple of nights, even though (V2) said she would not let (V4) take care of (R6)."

On 4-21-22 at 10:20 AM, V27 (Social Worker) stated that she has reported abuse allegations that R1 and R6 made against (V4) to (V2) and has not reported the allegations to (V1).

On 4-22-22 at 9:55 AM, V19 (Registered Nurse) stated that multiple residents (R5, R6, R7, R8, and R9) have had numerous reports of (V4) abusing them either physically, mentally, or verbally. V19 stated she has made (V2) aware of all of the allegations, and (V4) has continued to be allowed to take care of these residents. V19 stated, "I never notified (V1) of any of these allegations. Every time I would call (V1) with concerns he would tell me, 'What do you want me to do about it?' I did not even know that (V1) was the abuse coordinator."

On 4-20-22 at 12:15 PM, V11 (President of Board of Directors) stated, "(V1, Administrator) has never gotten back to me with the outcome or what has been done regarding all of the resident's allegations of abuse from (V4). I thought (V1) would have taken care of it."

On 4-20-22 at 9:45 AM V1 (Administrator) stated, "I have had no staff to resident abuse allegations made to me in the last six months."

On 4-21-21 at 8:45 AM V3 (ADON/Assistant Director of Nursing) stated, "(R1, R2, R4, R5, R6, R7, R8, and R9's) allegations of abuse regarding (V4) have never been reported to the State, investigated, and (V4) has not been suspended pending investigation. None of these allegations

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S9999	Continued From page 39 have been documented in the resident's clinical records. (V1) was made aware of the allegations regarding (R1) and (R4). (V4) is able to work all floors with all residents." On 4-22-22 at 9:30 AM (V2) stated, "I cannot find that an investigation was done regarding (R8 and R9's) allegations of abuse from (V4). I cannot find where (V4) has ever been suspended or removed from resident care for abuse allegations pending investigation." On 4-20-22 at 1:00 PM, V1 (Administrator) stated, "I trusted that (V2) would do the reports to the state and the investigations (regarding V4's abuse allegations). I did not have anything else to do with them once I turned them over to (V2) and (V3). I am the abuse coordinator. I do not recall any other allegations of abuse made to me about (V4) regarding (R1, R2, R4, R5, R6, R7, R8, or R9). (V4) has never been suspended pending an abuse investigation." (A)	S9999		