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	IL6000020	A. BUILDING: _____ B. WING _____	C 06/13/2022

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ABBINGTON VLGE NRSG & RHB CTR	31 WEST CENTRAL ROSELLE, IL 60172

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S 000	Initial Comments Investigation of Complaints: 2274183/IL147388 2274296/IL147536	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 300.3240a) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 i)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) Section 300.3240 Abuse and Neglect 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) Section 300.3240 Abuse and Neglect 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 regulations were not met as evidenced by: 1)Based on interview and record review, the facility failed to protect residents by immediately suspending an employee accused of abuse, pending the outcome of an investigation. The facility also failed to thoroughly investigate an allegation of abuse.	S9999		

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S9999	Continued From page 2 2)Based on interview and record review, the facility failed ensure a resident was free from mental/verbal abuse. These failures resulted in psychosocial harm expressed as fearfulness when discussing an incident when staff yelled at her (R10). This applies to all 54 residents residing in the facility. As a result of this failure, all facility residents were exposed to an alleged abuser, V3 (Social Services Director), while V3 was under investigation for abuse. Also as a result of this failure, all facility residents were at risk for abuse due to abuse investigations not being thoroughly conducted. The findings include: Facility Census, dated 5/31/22, shows the facility census was 54 residents. Preliminary Incident Investigation Report, faxed to IDPH (Illinois Department of Public Health) on 4/7/22, shows on 4/7/22 R10 alleged a staff member covered R10's ears. The report shows the facility will continue to conduct a complete and thorough investigation until a conclusion is reached. Final Incident Investigation Report, faxed to IDPH on 4/11/22, shows R10 alleged V3 (Social Services Director) put her hands over R10's ears and V3 screamed at R10. The abuse investigation concluded on 4/10/22 and the allegation was "not founded." 1. Face sheet, printed on 6/1/22, shows R10 was	S9999		

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admitted to the facility on 1/31/20. R10's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease with exacerbation, acute diastolic congestive heart failure, hypertension, Type 2 diabetes mellitus, anxiety disorder, major depression, peripheral vascular disease, morbid obesity, and history of falling.

MDS (Minimum Data Set), dated 4/20/22, shows R10's cognition was moderately impaired.

On 6/2/21 at 1:07 PM, R10 stated on 4/7/22 she began discussing a problem regarding her wheelchair with V1 (Administrator) when V3 (Social Services Specialist) involved herself in the discussion after R10 told V1, "I'll believe it when I see it." R10 stated V3 began arguing with R10 accusing R10 of calling V1 a liar. R10 stated she became upset, removed herself from the office, and went to her room. R10 stated when she got to her room, she received a call from her daughter asking why she called V1 a liar. R10 stated V3 called her daughter and accused R10 of calling V1 a liar. R10 stated she never called V1 a liar and R10 became very upset at V3 for calling her daughter. R10 stated V3 then came to her room as R10 was sitting on her bed facing the window. R10 stated V3 stood in front of R10 and R10 told V3 she didn't want to talk to her. R10 stated she told V3 to get out of her room and R10 put her hands over her ears because she did not want to hear or speak to V3. R10 stated V3 then put her hands over R10's hands and squeezed R10's hands onto her head. R10 stated she removed her hands and then put her fingers in her ears so she could not hear what V3 was saying. R10 stated she then grabbed her purse and threw it back toward the door. V3 continued to try to talk to R10, so R10 got up from the bed,

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S9999	Continued From page 4	S9999		

put her Bible in her wheelchair, grabbed her purse, and pushed her wheelchair out of the room. R10 stated V3 continued to yell at her as she left the room. R10 stated she had a signed statement from R12 stating R12 saw V3 go into R10's room and heard V3 yelling at R10. R10 produced a spiral notebook that included an entry from R12 which showed, "I [R12] witnessed Social Worker [V3] go into [R10's] room then heard them yelling back and forth. [V3] was yelling at [R10] for reasons unknown." The statement was signed by R12 and dated 4/7/22.

On 6/7/22 at 3:18 PM, R10 stated V3 went on and on yelling after R10 told V3 she did not want to talk to her. R10 stated V3 told R10 to "shut up." R10 stated V3 kept yelling at R10, so R10 decided to leave her room. R10 stated V3 kept yelling, "Stop! I'm not finished talking to you!" R10 stated V3 was too loud and R10 felt scared when V3 put her hands over R10's hands and squeezed her ears. R10 stated she told V3 to, 'stop, I got my glasses on!" R10 stated V3 was pushing the frame of her glasses into her temples. R10 stated there was nobody around and R10 did not want to be around V3 by herself. R10 stated she was uncomfortable around V3, and she was concerned what would happen when she was alone with V3. R10 stated V3 "can come down hard." R10 stated, "I was definitely scared." R10 stated, "I'm 73 years old in a wheelchair and I don't know what can go on. You don't know what will happen when I am alone with her." R10 stated she told V1 (Administrator) she was afraid of V3 and R10 was told to go directly to V1 with any of her concerns.

On 6/2/22 at 9:41 AM, V3 stated R10 became very upset during an earlier discussion with V1

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S9999	Continued From page 5 and V3 when R10 called V1 a liar. V3 stated she stepped and told R10 it was not nice to call V1 a liar and R10 responded, "I'm done f_____ with you!" R10 then left the area and went to her room. V3 stated she gave R10 approximately an hour (during which time she called R10's daughter) and then walked to R10's room to speak to her again. V3 stated when she spoke to R10 in her room she was standing in the doorway leaning against the back of the wall to the door. V3 stated when she arrived in R10's room, R10 was very angry with V3 for calling her daughter, told V3 to "get the f___ away from me," and threw items in her wheelchair. V3 stated she was telling R10 not to act that way and stood in her room as R10 exited the room. V3 stated afterward R10's daughter called and asked why she put her hands on R10 and V3 stated she never put her hands on R10. V3 stated R10 became angry with her because V3 called her daughter first and told her daughter R10 was calling V1 a liar. V3's progress notes, dated 4/7/22, show, "Writer approached resident room door and resident was sitting on the bed. Writer stated to resident 'can I explain to you somethings before you get t[too] upset for nothing?' Resident [then] stated 'you call my f_____ daughter who are you to call my f_____ daughter on me get the f___ out of my room.' Writer stated to resident 'I called your daughter because your daughter is your POA (Power of Attorney) and to make her aware of the conversation that just took place in my office.' Resident continue with the inappropriate tone and language and begin throwing items into her wheelchair that was sitting by the end of her bed. Writer stepped aside and allowed the resident to come out her room ...."	S9999		

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S9999	Continued From page 6 Preliminary Incident Investigation Report and Final Incident Investigation Report both fail to show V3 was suspended during the abuse investigation between 4/7/22 and 4/11/22. On 6/2/22 at 4:20 PM, V1 (Administrator) stated he did not suspend V3 during his investigation of alleged abuse toward R10 by V3. Time sheet, dated 4/5/22 - 4/13/22, shows V3 (Social Services Director) was present and working daily at the facility from 4/8/22 - 4/11/22 during the duration of the abuse investigation of R10. On 6/9/22 at 10:31 AM, V16 (Consultant) stated V3 was responsible for social services provided to all residents residing in the facility. On 6/8/22 at 10:10 AM, V15 (Physician) stated his expectation for the facility was that any staff alleged to have perpetrated abuse should be suspended during the abuse investigation until the investigation is concluded. Facility Abuse Prevention Program, dated 2/2017, shows "...Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee will not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated...." 2. On 6/2/22 at 1:07 PM, R10 stated she told V1	S9999		

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that she had a written witness statement from R12 in her notebook in her room, but she did not think V1 interviewed R12 during his abuse investigation. R10 produced a notebook with a signed witness statement from R12 stating he saw V3 walk into R10's room and heard V3 and R10 yelling while they were in the room. R10 stated she informed V1 that R12 witnessed the argument and alleged abuse between V3 and R10.

MDS, dated 4/10/22, shows R12's cognition was moderately impaired.

On 6/2/22, R12 stated he saw V3 walk into R10's room but was unsure how far into the room V3 walked. R12 stated R10 and V3 were "bickering and loud talking." R12 stated he could not see if V3 touched R10.

Preliminary Incident Investigation Report and Final Incident Investigation Report both fail to show V1 interviewed R12 as a potential witness to the alleged abuse being investigated.

On 6/1/22 at 4:20 PM, V1 (Administrator) stated he could not recall why he did not interview R12 during his abuse investigation. V1 stated he was aware R10 stated R12 witnessed the alleged abuse incident, however V1 failed to interview R12 for reasons he could not remember.

On 6/8/22 at 10:10 AM, V15 (Physician) stated his expectation was that all known witnesses to an abuse allegation should be interviewed during an abuse investigation.

Final Incident Investigation Report, faxed to IDPH on 4/11/22, shows R10 alleged V3 (Social Services Director) put her hands over R10's ears

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and V3 screamed at R10. The statement shows R10 stated R12 heard the interaction between V3 and R10. During the investigation, R12 was not interviewed. The abuse investigation concluded on 4/10/22 and the allegation was "not founded."

The final abuse investigation included an interview with R10, dated 4/8/22, which shows R10 reported she did not want anything to do with V3. R10 stated V3 entered her room yelling she wanted to talk to R10. R10 stated V3 kept yelling so R10 covered her ears with her hands. The statement shows V3 then placed her hands over R10's hands and V3 asked, "'Now can you hear?'" The statement shows R10 threw her purse toward the door of her room, got up and put the Bible, coffee, and then purse in her wheelchair.

The final abuse investigation included a statement from V3, dated 4/8/22, stating after R10 became angry and left V3's office, V3 called R10's daughter and then reapproached R10 in R10's room. The statement by V3 shows V3 was telling R10 not to be upset because there was nothing to be upset about. The statement shows R10 then placed her hands over her ears so she could not hear V3 and V3 stated she replied, "[R10] take your hands off your ears, you know we don't do that." V3's statement then shows R10 told V3 to, " ...get the f___ out of my room." The statement shows V3 continued to engage with R10 attempting to discuss her interaction with R10's daughter. The statement shows R10 then began to throw items in her wheelchair and exited the room with V3 standing in the room. The investigation included a statement signed by V1 and V3 showing V3 "has been educated when resident does not want to talk to her, then not to approach resident at the time."

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On 6/2/22 at 1:07 PM, R10 stated she told V1 that she had a written witness statement from R12 in her notebook in her room, but she did not think V1 interviewed R12 during his abuse investigation. R10 produced a notebook with a signed witness statement from R12 stating he saw V3 walk into R10's room and heard V3 and R10 yelling while they were in the room. R10 stated she informed V1 that R12 witnessed the argument and alleged abuse between V3 and R10.

Care plan initiated and effective 4/11/22 after R10's allegation of abuse on 4/7/22, shows "Manipulative Behavior - Resident exhibits manipulative behavior rt (related to) mental illness and maladaptive personality traits. Evidence by making false allegation towards other and involving peer into matters of hers."

Advanced Practitioner Nurse progress note, dated 5/19/22, shows no diagnoses of maladaptive personality disorder for R10. R10's psychiatric diagnoses include only insomnia and depression/anxiety.

Psychiatrist progress notes, dated 1/7/22, show R10's diagnoses include Major Depressive Disorder and anxiety. No diagnosis of maladaptive personality disorder for R10 were identified.

Facility Abuse Prevention Program Policy, dated 2/2017, shows, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. To do so,

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S9999	Continued From page 10 the facility has attempted to establish a resident sensitive and resident secure environment .... Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents .... Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident .... Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation ...." Abuse Prevention Program, dated 2/2017, shows "...4. Investigation Procedures. 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...." (B)	S9999		