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	IL6006126	A. BUILDING: _____ B. WING _____	C 06/23/2022

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S 000	Initial Comments Complaint Investigation: 2283928/IL147081 2284644/IL147969 Investigation of Facility Reported Incident of May 4, 2022/IL146975 Investigation of Facility Reported Incident of May 9, 2022/IL147059 Investigation of Facility Reported Incident of May 23, 2022/IL147788	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 300.3240a) 300.3240b) 300.3240d) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. 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. 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. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 2 A. Based on interview and record review, the facility failed to ensure that residents were free from physical abuse/assault from staff and fellow residents. This failure affected four residents (R1, R5, R13, and R14) of six residents reviewed for physical abuse/assault. As a result, R14 sustained a facial and arm injury from a physical assault by staff. B. Based on interviews and record reviews, the facility failed to thoroughly investigate an allegation of abuse. The facility also failed to follow its abuse policy to ensure resident's safety and well-being by not removing the alleged perpetrator from having access to the resident after an allegation of abuse. These failures have the potential to affect two residents (R1 and R14) of three residents reviewed for abuse policy implementation. Findings include: 1. R14's Resident Face Sheet documents that R14 was admitted to the facility on 2/16/22 with diagnoses including but not limited to chronic obstructive pulmonary disease with (acute) exacerbation, other psychotic disorder not due to a substance or known physiological condition, asthma, paranoid schizophrenia, cognitive communication deficit, generalized anxiety disorder, other abnormalities of gait and mobility, suicidal ideations and major depressive disorder. R14's BIMS (Brief Interview for Mental Status) dated 5/16/22 documents, in part, "The BIM score is considered to be on a continuum with a score of 9 or less indicating some level of cognitive impairment and a 10 or greater being an indicator of intact cognitive function." R14 scored a 12.	S9999		

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S9999	Continued From page 3 R15's BIMS dated 6/6/22 documents, in part, that R15 scored a 15. On 6/16/22 at 12:10 pm, the surveyor interviewed R15 (R14's roommate) regarding witnessing any physical abuse from staff upon R14. R15 stated, "They beat each other up. They used their hands. R14 had blood all over R14's face from R14's eyes." R15 added that this incident occurred in the morning at the doorway of R14 and R15's room. On 6/16/2022 at 12:43 pm, V11 (Social Services Director) stated that V11 was not aware of this incident prior to being notified of the complaint on 6/15/22 at which point the investigation was started. V11 stated. "We don't report resident on staff abuse. We took the job, so it comes with the territory." On 6/16/22 at 2:40 pm, the surveyor conducted a phone interview with V13 (LPN/Licensed Practical Nurse) who stated, "From what I can remember, (R14) was in a manic state. (R14) attacked me. I tried to redirect (R14), but (R14) scratched me under my eyeballs so I couldn't really see." V13 added, "I was just trying to get away from (R14). I don't recall physically touching (R14)." V13 stated that after V14 (CNA/Certified Nursing Aide) intervened, V13 left the unit and called the supervisor about the incident. V13 stated that V13 left the building at that time and, "I haven't been back." The surveyor attempted to reach V14 for interview on 6/16/22 at 2:30 PM. Voicemail was left. Second attempt was at 2:47 PM with no answer and another voicemail was left.	S9999		

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S9999	Continued From page 4 On 6/21/22 at 12:03 pm, V3 (Assistant Administrator) attempted to review the camera footage from 5/31/22 but was unable to locate the video stating, "I don't know how to go back. I'm not good with electronics." V3 added that V3 believes the cameras only save recordings for 1-2 weeks. On 6/21/22 at 1:27 pm, the surveyor conducted a phone interview with R14 in the presence of V16 (the hospital social service staff member). R14 stated that on 5/31/22, R14 got up around 4 am to ask V13 for some Tylenol. R14 could not recall if V13 was asleep at the time but stated, "V13 was all worked up about something." R14 stated that V13 told R14 to go back to the room and "charged at me with a syringe and needle in V13's hand." When V13 did not back down, R14 and V13 "got in a fist fight," per R14. R14 stated that V13 threw the first punch at R14's eyes, causing a scratch on the left eye that bled. R14 stated that I (R14) then scratched V13's face. Also, R14 stated that V13 took a "Proceed with Caution" sign and hit R14 over the head "about 10 times." This statement corroborates the complainant's allegation that states the complainant "witnessed V13 grabbing a 'Caution Floor is Wet' sign and started beating R14 with it." R14 added, "I had a bruise to my right arm. It's still there." V16 was asked to confirm if the bruise is still there and stated, "I see that there is something there, but I don't know what it is. Nor can I say that it is from the incident you are all talking about." On 6/22/22 at 2:00 pm, the surveyor inquired if V11 interviewed R14's roommate, R15, as part of the investigation since there was no resident statement from R15 found in the facility reportable. V11 replied, "Yes. When I talked to	S9999		

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(R15) directly, (R15) said (R15) was asleep at the time of the incident. So, I guess I could've wrote that." V11 stated that V11 did not include R15's interview in the resident statements and did not review any hospital records relating to R14's hospitalization on 5/31/22. V11 stated that with any type of physical altercation, "we do a body assessment," and that there were no injuries documented in the nurse's report when R14 left the facility. The surveyor asked, hypothetically, if R14 was injured during this incident would that have to be reported as abuse? V11 replied, "Yes, that would have to be reported by the nurse immediately because we have a two-hour window to submit a reportable to the state." V11 added that the staff member involved would be sent home immediately pending the investigation.

On 06/22/22 at 1:34 pm, V3 (Assistant Administrator) stated V3 is an abuse coordinator. V3 stated that V13 was allowed to continue working after 5/31/22 because it was only reported to V3 that R14 attacked V13. V3 stated that V3 was unaware of any abuse towards R14 which is why no investigation was started at that time. When the surveyor asked why V13 has not been working since 6/9/22, V3 stated, "I have no clue why (V13) just stopped." V3 added that V3 has heard rumors that V13 didn't want to "deal with this" anymore. According to V3, V13 has been terminated due to failure to show up for work.

On 6/22/22 at 4:18 pm, V19 MD (Medical Doctor/R14's Primary Physician) denied being notified of R14 sustaining any injury at the time that was notified that "R14 attacked 11pm -7 am nurse (per nursing progress note dated 05/31/22)," ordering R14 to be sent to the hospital for a psychiatric evaluation. Regarding taking

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S9999	Continued From page 6 care of psychiatric residents, V19 stated, "You have to treat them as a human being. Stay calm." On 6/22/22, the surveyor attempted to reach V14 at 9:16 am and 10:26 am with no success. R14's ED (Emergency Department) Provider Report documented by V18 (ED Physician) documents, in part, "History of Present Illness, Initial Comments: (R14) came from nursing home with agitation and aggressive behavior. (R14) was involved in an altercation with nursing staff and sustained injury to left facial region and also left forearm. (R14) states (R14) was pinched and poked..." R14's hospital History and Physical dated 5/31/22 documented by V15 (Hospital Admitting Physician) documents, in part, "History of present illness: (R14) seen in ER (Emergency Room) room 11 with a hx (history) of aggressive behavior/agitation. (R14) reportedly had altercation with the nh (nursing home) staff resulting in physical injury to (R14's) face/arm." R14's ED (Emergency Department) Patient Notes documented by V17 RN (Registered Nurse) documents, in part, "(R14) with dried blood on shirt and near left eye..." R14's nursing progress note dated 5/31/22 at 6:30 am documents, "(R14) attack 11-7 nurse hitting (nurse) in face resident transfer to (Named) Hospital for psych eval per V19 MD (Medical Doctor). R14's progress notes show no documentation of any physical injury to R14, or any full body assessment completed at the time of transfer to the hospital on 5/31/22.	S9999		

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S9999	Continued From page 7 R14's facility nursing progress noted dated 6/10/22 at 7:30 pm documents, in part, "Readmitted...Refuse Physical assessment noted facial redness ..." R14's Full Clinical/Body Observation dated 6/10/22 documents, in part, "Skin: Describe any additional body marks: facial redness." A previous Full Clinical/Body Observation was documented on 05/06/22. R14's facility nursing progress note dated 6/14/22 documents, in part, "(R14) has eye appointment... (R14) informed of appointment." V13's timecard documents that V13 punched in at 12:35 am on 5/31/22 and punched out at 6:30 am on 5/31/22. V13's timecard also documents that V13 worked on 06/02 (2:54 am - 8:00 am), 06/04 (1:12 am - 7:00 am), 06/07 (12:51 - 7:00 am) and 06/09 (1:53 am -7:00 am). R14's Abuse Risk Review dated 5/13/22 documents, in part, "Section 1: Identify an areas of abuse the resident has experienced or may be at risk for: physical, verbal, mental; Does the resident have any of the following risk factors (select all that apply): confusion/disorientation, communication barriers, low self-esteem/self-worth." R14's care plan dated 3/10/22 documents, in part, "R14 has a diagnosis of paranoid schizophrenia, psychotic disorder, suicidal ideations, schizoaffective disorder. Approach: Assess if behavior endangers others, intervene if necessary; Avoid physical contact with R14; closely supervise R14; Assist R14 to identify effective coping mechanisms; Maintain a calm	S9999		

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S9999	Continued From page 8 environment and approach to R14." The facility policy titled "Abuse Prevention Policy" dated February 2017 documents, in part, "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. Definitions: ... Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Amd. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines) ... Procedures: V. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer ...Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but no more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery	S9999		

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S9999	Continued From page 9 of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration or pain. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property. VI. Protection of Residents: 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 shall 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. VII. Internal investigation: 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 4. Investigation procedures: The appointed investigator will, at minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any pertinent medical records or other documents will be reviewed. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed and a summary will be used for reporting purposes." 2. On 5/31/22 at 10:20am V3 (Assistant	S9999		

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Administrator) presented the facility's initial and final incident reports sent to the state agency. Both the initial report dated 5/9/22, and the final report dated 5/13/2022 that were sent to the State Agency regarding the allegation that a staff member physically abused a resident (R1) were reviewed. V3 explained that the staff (V10) was terminated. At this time, V3 presented V10's Employee File which was reviewed. According to the employee report dated 5/9/22, V10 was suspended pending the investigation. On 5/13/22, V10 was terminated due to the allegation of abuse being substantiated per the facility's investigation. The final facility incident report dated 5/13/22 documents, in part, "Investigation completed. Writer interview staff and several resident as possible witnesses. As a result, the allegation was substantiated. R1 was physically attacked by staff."

Facility's occurrence report dated 5/7/22 at 12:15pm shows that on 5/7/22 at 12:15pm, V5 (LPN/Licensed Practical Nurse caring for R1) completed a facility occurrence report about this allegation of abuse on the same day 5/7/22.

On 6/2/22 at 11:20am, V5 was interviewed about the allegation of abuse made by R1 that she (V5) reported on 5/7/22, according to the occurrence report. V5 stated that she (V5) did not witness the incident. V5 was not sure of the exact day that she (V5) reported the incident.

V3 also presented V10's timecard that shows that V10 clocked in on 5/8/22 at 7:23am and clocked out at 3:00pm, showing that V10 was allowed to work at the facility the day after the occurrence reporting was made by V5, regarding the allegation that R1 was attacked by V10.

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S9999	Continued From page 11 On 6/1/22 at 3:53pm, V3 was interviewed regarding the facility's expectation of a staff member who receives a complaint of abuse from a resident. The surveyor inquired about when abuse should be reported. V3 stated "Yes, that nurse should have reported it if she had witnessed it or if the nurse did not witness the event, but the resident told the nurse what had happened, then it should have been reported that day." Several efforts were made to reach V10 for interview, but without success. On 6/1/22 at 11:19 am, the surveyor inquired about the witness statements and pointed out the final incident report dated 5/13/22 to V11 (Director of Social Services) documenting, "Writer interview staff and several residents as possible witnesses." V11 stated that there was only a staff member that witnessed the event. V11 added that the incident happened in the room when no other residents were present. Referring to the documented statement, V11 stated, "That was a typo on my part. There were no resident witnesses." V11 stated that V12 LPN (Licensed Practical Nurse) told V12's supervisor that V12 witnessed the incident, but that V12 didn't talk to V11 directly. V11 looked through the incident report and stated, "We're missing a statement from (V12)." V12 was later interviewed on 6/2/22 at 11:41am and V12 explained that she (V12) did not remember what she(V12) reported. On 6/21/22 at 2:35pm, V11 was interviewed regarding his role in abuse investigation. V11 stated "I'm supposed to investigate all staff to resident and resident to resident abuse	S9999		

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S9999	Continued From page 12 allegations." On 06/01/2022 at 1:43 PM, during an interview with R1 about the incident, R1 stated that there was no one in R1's room at the time of the incident. R1 stated that V10 was putting ice in the pitcher as R1 was standing in the doorway of R1's room. V10 then threw the ice at R1. R1 stated, "I don't know what was on that man's mind." R1 stated that R1 then closed the door to R1's room and was holding the door with R1's foot when V10 pushed the door open and began to "hit me with (V10's) fists on my face." R1 stated that R1's lip and mouth were bleeding but added that R1 was not taken to the hospital at that time. R1's MDS (Minimum Data Set) dated 2/2/22 documents R1 scored a 12 out of 15 on the BIMS (Brief Interview for Mental Status), indicating R1's cognition is moderately impaired. R1's Resident Face Sheet documents, in part, R1's medical diagnoses of schizophrenia, primary osteoarthritis, right shoulder; type 2 diabetes mellitus, hypertensive heart disease and anemia. R1's care plan dated 2/3/22 documents, in part, "Problem - Category: Psychosocial Well-Being - Trauma: R1's comprehensive assessment reveals a history of substance abuse/chemical dependency and suspected abuse and/or neglect or factors that "MAY" increase R1's susceptibility to abuse or neglect ... Approach: Establish a psychosocial, therapeutic, milieu for R1. Observe R1 for signs of fear and insecurity during delivery of care. Take steps to calm R1 and help R1 feel safe." The facility policy titled "Abuse Prevention Policy"	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006126	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 dated February 2017 documents, in part, "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. This will be done by ...Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; Implementing systems to promptly and aggressively investigate all reports and all allegations of abuse, neglect, exploitation, and mistreatment, and making the necessary changes to prevent further occurrences; Filing accurate and timely investigative reports. Definitions: ... Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Amd. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines)." The facility did not follow this policy. 3. On 5/31/22 at 11:45 am, R5 (alleged victim) was observed to be calm and cooperative. R5 was interviewed regarding the incident of 5/4/22 with his roommate R4. R5 stated that R4 (alleged perpetrator) punched him (R5) on the left side of the cheek and his cheek was swollen, and they did an X-Ray on his (R5) cheek. R5 denied hitting R4 at any time and R5 explained that R4 was removed from the room, showing the surveyor the empty bed. R5's BIMS (Brief Interview for Mental Status) dated 12/3/2021 was 14 out of 15 (cognitively intact). Also, R4's BIMS Score dated 5/19/22 was 14 out of 15 (cognitively intact).	S9999		

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S9999	Continued From page 14 On 5/31/22 at 12pm, the surveyor attempted to speak with R4, but R4 stated that he did not want to speak with the surveyor. R4's face sheet shows that R4 has multiple diagnoses that includes but are not limited to schizophrenia. R5's face sheet also shows a diagnosis of schizophrenia. On 5/31/22 at 10:10 am, V3 (Assistant Administrator) presented the facility's preliminary and final investigation reports that were sent to the State Agency. These reports were both dated 5/4/22. The final investigation report states in part: On 5/4/22 at approximately 10am, (R4) became angry and punched (R5) in the face because he was talking too much. As a result, the allegation was substantiated. (R4) was having a psychotic episode, walked over to (R5) and punched him (R5) in the face. (R4) was sent to the hospital for psychiatric evaluation and (R5) was checked out by NOD (Nurse on Duty). X-Ray will be requested on left cheek area. R5's X-Ray report dated 5/14/22 (ten days later) states: Unremarkable facial bone series without obvious radiologic evidence of fracture. R4's progress notes dated 5/4/22 at 10:05 am written by V5 (LPN/Licensed Practical Nurse) states that R4 hit his roommate in the face with a closed fist. On 6/1/22 at 11:44 am, V11 (Director of Social Services) presented the social services progress notes for both R4 and R5 which were reviewed. 4. On 6/16//22 at 11:50 am, V3 presented the facility's investigation reports that were sent to the	S9999		

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S9999	Continued From page 15 State Agency. These reports were dated 5/23/22. The final investigation report sent by V11 states in part that R12 struck R13 with open hand at the back of his (R13's) head, and that R12 was very delusional at the time of the assault. On 6/16/22 at 12:15 pm, R13 was interviewed regarding the incident of the alleged physical abuse by R12. R13 stated that R12 punched him (R13) at the back of the head, but that it was not too painful, and that the pain is no longer there. R13's BIMS (Brief Interview for Mental Status) dated 4/6/22 was 15 out of 15 (cognitively intact). On 6/16/22 at 1:44 pm, V11 stated that R12 was having a delusion and very symptomatic at the time R12 hit R13. At this time, V11 presented the social services progress notes and care plans for both R12 and R13. These were reviewed and show that R12 has a history of aggressive behavior and that R12 was sent to the hospital for psychiatric evaluation. MAR (Medication Administration Records) and POS (Physician Order Sheets) for both R12 and R13 were reviewed. "B"	S9999		