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
	IL6015192	A. BUILDING: _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 12/22/22/ IL155134	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.780b) 330.780c) Section 330.780 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement is not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review the facility failed to notify IDPH (Illinois Department of Public Health) within 24 hours after a reportable incident that occurred and send a narrative summary of the reportable incident for a resident that resulted in bruises and a hematoma to her arms for 1 of 3 residents (R1) reviewed for incidents in the sample of 3. The findings include: The Nurse's Progress Note dated 12/22/22 at 9:50 PM showed, "Resident assistant on duty called this writer to inform him that the resident had a large bowel movement and that the resident was being aggressive while providing care. Rushed to the bedroom and the resident was noted sitting at the edge of the bed holding a diaper tightly with feces on her hands. This writer explained to the resident that we needed to clean her. While assisting the resident, the resident was noticed to be upset, screaming, yelling, attempting to hit, bite and kick the resident assistants and this writer. Health and Wellness Director informed of the incident. Endorsed to AM nurse to inform the doctor and POA (power of attorney) in the morning." The Outside Agency - Wound Care Note dated 12/23/22 for R1 showed R1 had existing wounds plus the following new areas of discoloration, "Wound care...left forearm big hematoma noted with skin intact; left forearm below elbow 12 cm x 11 cm bruise; Left forearm hematoma open to air." The Assisted Living and Sheltered Housing Incident Report dated 12/28/22 for R1 showed, "Incident/Accident date: 12/22/22; Incident time: 10:54 PM. R1 noted with bruises to arms and	S9999		

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S9999	Continued From page 2 complained they were rough with her. Investigation complete. Employees involved were suspended pending investigation. Corrective action was taken." The email cover letter for the incident notifying IDPH (Illinois Department of Public Health) was dated 12/28/22 at 5:13 PM. The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed, "R1 stated that four men beat her up. She stated a Chinese man came in her room and she replied to him, "You can't come in; I'm trying to fix my leg." R1 stated, "He came back to her room with four people. They all put my dress over my head, I had no clothes on. They were all doing terrible things. They threw me around and walked out. They thought it was funny, laughed through the whole thing." The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed it was a written statement by V7 LPN (Licensed Practical Nurse) that she got an endorsement from the night nurse to relay to the nurse practitioner, director and POA (power of attorney) about R1 being aggressive with staff and not wanting to be cleaned which resulted in discoloration of R1's skin. V7 went and inspected R1's skin and found areas of discoloration to the left forearm that was 12 x 11 cm; right hand near her wrist that measured 5 x 6 cm and to the right inner wrist that was 0.3 cm. V7 stated R1 was sad and complained of pain. R1 was seen by the the nurse who covered the discoloration on R1 to prevent it from opening. V7 endorsed to the oncoming nurse that RA's (Resident Assistants) were not to force R1 with care; per POA R1 goes to bed late and wakes up late." On 12/30/22 V2 DON (Director of Nursing)	S9999		

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S9999	Continued From page 3 interviewed V4 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "V4 stated that V8 went for help. He told V8 that they need to ask V5 for help as they can't touch her. He stated, "We have to ask V6. V6 said we can't leave her like this, that they need to change her and clean the room." V4 stated that V6 was holding her hands, V5 was holding her legs, and he and V8 were cleaning her. V6 told R1 she needs to be cleaned. R1 refused, she was hitting and yelling. V6 was holding her calmly." On 12/30/22 V2 DON (Director of Nursing) interviewed V5 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "Per V5, he states that V8, the caregiver, called for help. He stated to V8. "We can't do this, call V4. R1 was already shouting and I said we needed to call V6 LPN. V6 said we can't leave her like that." V5 stated that V6 was holding R1's hands, he was holding her back, V4 was holding her legs and V8 was getting wipes and cleaning the wheelchair. We were very gentle holding her down, this is not the first time she has been like this. We explained that she needs to be cleaned. Her reaction was shouting." On 12/30/22 V2 DON (Director of Nursing) interviewed V6 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "Per V6, he was holding R1's hands, V5 was holding her back, V4 was holding her feet, and V8 was wiping her. V6 stated, "I was holding her at her own force, she was trying to hit, I was not pressing hard. I told her we needed to clean her, she started to fight, she was swearing at us." When asked if he tried anything else, he stated, "No, I didn't try anything else."	S9999		

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S9999	Continued From page 4	S9999		

The Assisted Living and Sheltered Housing Incident Report dated 1/4/23 for R1 showed, "Incident/Accident date: 12/22/22. R1 noted with bruises to arms and complained they were rough with her. Investigation complete. Corrective action was taken."

On 1/11/23 at 11:50 AM, V12 (Memory Care Director) stated staff should report any incidents and/or abuse immediately within 2 hours. V12 stated the staff can tell the nurse and then the nurse can contact us immediately if we are not in the building. I was told about what happened the next day by a CNA. I was told an incident occurred the previous night and R1 had bruises. V2 DON (Director of Nursing) and V3 ADON (Assistant Director of Nursing) already knew about it and told me the next morning in the morning meeting. "

On 1/13/23 at 12:20 PM, V2 DON stated, "Mainly myself, V1 (Executive Director) and V3 ADON conduct abuse investigations. V6 LPN notified me on 12/22/22 at 10:00 PM of what happened. I let V1 know. It was a holiday weekend so we may have started the investigation on 12/27/22. We reported the incident to IDPH (Illinois Department of Public Health) on 12/28/22. We were supposed to report it within 24 hours." V2 stated they follow the facility's Abuse policy for reporting. V2 stated it took them 1.5 weeks to complete the investigation.

The Facility's Allegations of Abuse/Neglect/Exploitation Prevention policy (10/2021) showed, "Reporting requirements: The act of alleged abuse, neglect or exploitation must be reported immediately up to 24 hours after the allegation to the state licensing agency via the preferred method of notification." A policy for

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S9999	Continued From page 5 reporting incidents was requested from the facility on 1/11/23; however, the policy was not received. 330.1145a) 330.1145c) 330.1145d) Section 330.1145 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. c) Physical restraints shall only be used in an emergency as specified in Section 330.1150. d) Physical restraints shall not be used on a resident for the purposes of discipline or convenience. This requirement is not met as evidenced by: Based on interview and record review the facility	S9999		

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S9999	Continued From page 6 failed to ensure a residents with dementia and behaviors was not physically restrained during care for 1 of 3 residents (R1) reviewed for restraints and abuse in the sample of 3. The findings include: The Face Sheet dated 1/11/23 for R1 showed diagnoses including vascular dementia and major depressive disorder. The Nurse's Progress Note dated 12/22/22 at 9:50 PM showed, "Resident assistant on duty called this writer to inform that the resident had a large bowel movement and that the resident was being aggressive while providing care. Rushed to the bedroom and the resident was noted sitting at the edge of the bed holding a diaper tightly with feces on her hands. This writer explained to the resident that we needed to clean her. While assisting the resident, the resident was noticed to be upset, screaming, yelling, attempting to hit, bite and kick the resident assistants and this writer. Health and Wellness Director informed of the incident. Endorsed to AM nurse to inform the doctor and POA (power of attorney) in the morning." The Outside Agency - Wound Care Note dated 12/23/22 for R1 showed R1 had existing wounds plus the following new areas of discoloration, "Wound care...left forearm big hematoma noted with skin intact; left forearm below elbow 12 cm x 11 cm bruise; Left forearm hematoma open to air." The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed, "R1 stated that four men beat her up. She stated a Chinese man came in her room and	S9999		

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S9999	Continued From page 7 she replied to him, "You can't come in; I'm trying to fix my leg." R1 stated, "He came back to her room with four people. They all put my dress over my head, I had no clothes on. They were all doing terrible things. They threw me around and walked out. They thought it was funny, laughed through the whole thing." The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed it was a written statement by V7 LPN (Licensed Practical Nurse) that she got an endorsement from the night nurse to relay to the nurse practitioner, director and POA (power of attorney) about R1 being aggressive with staff and not wanting to be cleaned which resulted in discoloration of R1's skin. V7 went and inspected R1's skin and found areas of discoloration to the left forearm that was 12 x 11 cm; right hand near her wrist that measured 5 x 6 cm and to the right inner wrist that was 0.3 cm. V7 stated R1 was sad and complained of pain. R1 was seen by the the nurse who covered the discoloration on R1 to prevent it from opening. V7 endorsed to the oncoming nurse that RA's (Resident Assistants) were not to force R1 with care; per POA R1 goes to bed late and wakes up late." The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed it was a written statement by V8 CNA (Certified Nursing Assistant) that stated when he walked into R1's room at 8:50 PM or 9:00 PM, R1 was covered with feces. V8 noticed that R1 did not want him to take care of her so he went to get V4 CNA to help her instead. V4 entered R1's room and then came out saying R1 did not want him to help. V8 stated he went and got V5 CNA and the same thing happened. V4 and V5 told V8 to get V6 LPN (Licensed Practical Nurse) and all	S9999		

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S9999	Continued From page 8 three of them proceeded to put R1 in bed against her will. R1 was to be left alone. V8 grabbed R1's clothing with her long sleeves up to prevent her from hurting others and herself. V8 stated as they proceeded to change R1 she was swinging her arms and hit people. V8 stated V4 and V5 were cleaning below R1's waist level while V8 was holding R1's arms down. V8 stated he did not touch R1 other than to put the incontinence brief on the resident. The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed it was an email from V4 CNA (Certified Nursing Assistant) that stated V8 was assigned to group "C" and according to V8 he had went in several times to change R1 but she refused. The shift was coming to an end and V8 was looking for assistance on how to change R1. V4 stated V8 called him to R1' room and R1 had a huge bowel movement and some of it was dry. R1 had been trying to help herself and had messed her entire room. V4 stated when he went in he asked V8 to call V5 because, "the mess was a lot." V4 stated when V5 came in with them he asked them not to touch her and call V6 LPN. V4 stated when V8 came in the situation was overwhelming and he said they couldn't leave R1 like this. V4 stated there were two of us holding R1 and two of them cleaning her up. V4 stated photo and videos were taken to see the situation that warranted them changing her. The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed it was a written statement by V5 CNA (Certified Nursing Assistant) that stated that all he could recall was the him, V8, and V4 were doing their routine work putting residents in their rooms. One of the them called him to help with R1	S9999		

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S9999	Continued From page 9	S9999		

because she was resisting being cleaned. V5 and V8 went together and R1 was sitting in her own bowel movement on her wheelchair. V5 stated he told R1 that she needed to be cleaned but she was already shoving them. V5 stated he told V4 to get V4 so he could help too. When V4 came and saw the situation he said to get V6 LPN to help with the situation. V6 came and told them they couldn't leave R1 like that because it would be neglect to the resident. V6 made the decision to clean R1 on her bed so they followed that decision. V5 stated when R1 was placed on the side of her bed she was very combative; trying to shove and grab them. V5 stated V6 grabbed the sleeve of R1's sweatshirt to avoid bruises. V4 was holding R1's legs and he (V5) was holding R1's hip and back while V6 was holding R1 V5 stated when they went to turn R1, V6 loosened her hand and R1 grabbed his shirt and neck tight. V5 stated he almost choked. V6 grabbed R1's hands but she was really punching him (V5). V5 stated they told R1 to stop. V5 stated after they were done he told V6 if there were bruises this was going to be a big issue and V6 stated he would do an incident report.

The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22 showed it was a written statement by V6 LPN (Licensed Practical Nurse) and showed on 12/22/22 on the evening shift he was called to R1's room and R1 was aggressive when care was being provided. V6 stated, "This writer went to R1's room and noticed R1 sitting on the bed with her hands holding a soiled diaper; noted feces on the resident's hand and wheelchair. Explained to R1 that we need to clean her. While assisting R1, she was trying to hit and bite this writer and resident assistants. A couple of hours later the resident assistant reported bruises to

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S9999	Continued From page 10 both arms and hands. It was never my intention to cause these bruises. I assisted the resident as gently as possible." On 12/30/22 V2 DON (Director of Nursing) interviewed V4 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "V4 stated that V8 went for help. He told V8 that they need to ask V5 for help as they can't touch her. He stated, "We have to ask V6. V6 said we can't leave her like this, that they need to change her and clean the room." V4 stated that v6 was holding her hands, V5 was holding her legs, and he and V8 were cleaning her. V6 told R1 she needs to be cleaned. R1 refused, she was hitting and yelling. V6 was holding her calmly." On 12/30/22 V2 DON (Director of Nursing) interviewed V5 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "Per V5, he states that V8, the caregiver, called for help. He stated to V8. "We can't do this, call V4. R1 was already shouting and I said we needed to call V6 LPN. V6 said we can't leave her like that." V5 stated that V6 was holding R1's hands, he was holding her back, V4 was holding her legs and V8 was getting wipes and cleaning the wheelchair. We were very gentle holding her down, this is not the first time she has been like this. We explained that she needs to be cleaned. Her reaction was shouting." On 12/30/22 V2 DON (Director of Nursing) interviewed V6 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "Per V6, he was holding R1's hands, V5 was holding her back, V4 was holding her feet, and V8 was wiping her. V6 stated, "I was holding her at her own force, she was trying to hit,	S9999		

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S9999	Continued From page 11 I was not pressing hard. I told her we needed to clean her, she started to fight, she was swearing at us." When asked if he tried anything else, he stated, "No, I didn't try anything else." On 1/11/23 at 11:50 AM, V12 (Memory Care Director) stated that the shelter care unit follows the state shelter care regulations. V12 stated staff know how to take care of residents with dementia and behaviors. V12 stated it is never okay to hold a resident down. It sounds like they tried to restrain R1 and it is not okay." On 1/11/23 at 12:20 PM, V2 DON (Director of Nursing) stated, 'We are a restraint free facility. Staff are not allowed to do any restraints. The resident (R1) was restrained and that is why those involved were terminated. I don't think there were any malicious thoughts just poor decision making. They were not attempting nor intended to hurt R1. The staff have been trained on abuse, dementia care and behaviors. We have dementia care training quarterly. We recently had abuse training. We follow the state shelter care regulations." The facility's Restraint Free Environment policy (4/2022) showed, "It is the policy of the facility to support a restraint free environment. Each resident in the assisted living facility/personal care home has the right to be free from physical and mental abuse, including corporal punishment or physical and chemical restraints. A resident is not restrained utilizing any method, device, material or equipment that cannot be removed by the resident, and or that restricts freedom of movement or normal access to one's body. A resident is not to be restrained for punishment, convenience of staff, or with the use of excessive drug doses."	S9999		

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S9999	Continued From page 12 330.4240a) 330.4240c) 330.4240d) 330.4240e) Section 330.4240 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) (A, B) 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. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. 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) This requirement is not met as evidenced by:	S9999		

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	IL6015192	A. BUILDING: _____ B. WING _____	C 01/12/2023

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S9999	Continued From page 13 Based on interview and record review the facility failed to ensure staff were removed from care pending the outcome of an allegation of abuse on 12/22/22 for 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: The Face Sheet dated 1/11/23 for R1 showed diagnoses including vascular dementia and major depressive disorder. The Nurse's Progress Note dated 12/22/22 at 9:50 PM showed, "Resident assistant on duty called this writer to inform that the resident had a large bowel movement and that the resident was being aggressive while providing care. Rushed to the bedroom and the resident was noted sitting at the edge of the bed holding a diaper tightly with feces on her hands. This writer explained to the resident that we needed to clean her. While assisting the resident, the resident was noticed to be upset, screaming, yelling, attempting to hit, bite and kick the resident assistants and this writer. Health and Wellness Director informed of the incident. Endorsed to AM nurse to inform the doctor and POA (power of attorney) in the morning." The Outside Agency - Wound Care Note dated 12/23/22 for R1 showed R1 had existing wounds plus the following new areas of discoloration, "Wound care...left forearm big hematoma noted with skin intact; left forearm below elbow 12 cm x 11 cm bruise; Left forearm hematoma open to air." The Internal Investigation Statement dated 12/28/22 for R1 and the incident of 12/22/22	S9999		

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S9999	Continued From page 14 showed, "R1 stated that four men beat her up. She stated a Chinese man came in her room and she replied to him, "You can't come in; I'm trying to fix my leg." R1 stated, "He came back to her room with four people. They all put my dress over my head, I had no clothes on. They were all doing terrible things. They threw me around and walked out. They thought it was funny, laughed through the whole thing." On 12/30/22 V2 DON (Director of Nursing) interviewed V4 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "V4 stated that V8 went for help. He told V8 that they need to ask V5 for help as they can't touch her. He stated, "We have to ask V6. V6 said we can't leave her like this, that they need to change her and clean the room." V4 stated that V6 was holding her hands, V5 was holding her legs, and he and V8 were cleaning her. V6 told R1 she needs to be cleaned. R1 refused, she was hitting and yelling. V6 was holding her calmly." On 12/30/22 V2 DON (Director of Nursing) interviewed V5 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "Per V5, he states that V8, the caregiver, called for help. He stated to V8. "We can't do this, call V4. R1 was already shouting and I said we needed to call V6 LPN. V6 said we can't leave her like that." V5 stated that V6 was holding R1's hands, he was holding her back, V4 was holding her legs and V8 was getting wipes and cleaning the wheelchair. We were very gentle holding her down, this is not the first time she has been like this. We explained that she needs to be cleaned. Her reaction was shouting." On 12/30/22 V2 DON (Director of Nursing)	S9999		

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S9999	Continued From page 15 interviewed V6 and the Internal Investigation Statement regarding the incident on 12/22/22 for R1 showed, "Per V6, he was holding R1's hands, V5 was holding her back, V4 was holding her feet, and V8 was wiping her. V6 stated, "I was holding her at her own force, she was trying to hit, I was not pressing hard. I told her we needed to clean her, she started to fight, she was swearing at us." When asked if he tried anything else, he stated, "No, I didn't try anything else." The facility's Nursing Schedule showed V6-LPN worked 12/25/22, 12/26/22, 12/29/22 and 12/30/22. The Employee Timesheet for V6 showed he worked on 12/24/22, 12/25/22, 12/26/22 and on 12/28/22 from 7:00 AM to 1:30 PM. The Caregiver's Schedule showed V4 worked 12/23/22 & 12/26/22. The Employee Timesheet for V4 showed he worked on 12/23/22 and 12/26/22. The Caregiver's Schedule showed V5 worked 12/26/22 & 12/27/22. The Employee Timesheet for V5 showed he worked 12/26/22 and 12/27/22. On 1/11/23 at 12:20 PM, V2 DON (Director of Nursing) stated, 'The resident (R1) was restrained and that is why those involved were terminated. The staff involved were suspended on 12/28/22. They worked their normal shifts until 12/28/22. If something comes up like the allegation they should be suspended right away and that wasn't done." The Facility's Allegations of Abuse/Neglect/Exploitation Prevention policy (10/2021) showed, "Investigation of alleged abuse, neglect, and exploitation procedures - Any	S9999		

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S9999	Continued From page 16 staff members suspected of abuse shall be suspended during the investigation process." (B)	S9999		