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	IL6000483	A. BUILDING: _____ B. WING _____	C 08/14/2023

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FOREST VIEW REHAB & NURSING CENTER	535 SOUTH ELM ITASCA, IL 60143

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S 000	Initial Comments Complaint Investigations: 2375889/IL162130 2376111/IL162394	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3210t) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. Section 300.3210 General	S9999		

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S9999	Continued From page 2 t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident, R1 was free from physical abuse from another resident, R11; failed to implement interventions to keep R1 free from further abuse by R11; failed to implement a treatment plan to keep other residents safe from R11's behaviors; failed to investigate alleged physical abuse to prevent further abuse or mistreatment from occurring; failed to validate physical abuse and implement training after an allegation of physical abuse; and failed to thoroughly assess and monitor a resident a resident's condition after an allegation of physical abuse. This applies to one (R1) of seven residents reviewed for physical abuse in a sample of 16. This failure has the potential to affect the other 24 residents residing in this unit with R11. This unit is the facility's Dementia Unit cares for residents at risk for abuse related to their cognitive impairment and inability to verbalize needs. The findings include: The EMR (Electronic Medical Record) showed R1's original admission to the facility was on 5/3/2018. R1 was readmitted on 1/19/2022. R1 was discharged home on 7/26/2023 because R1's family refused for R1 to return to the facility.	S9999		

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S9999	Continued From page 3 R1, an 81-year-old and with multiple diagnoses including Parkinson's Disease, neurological deficits, repeated falls, difficulty in walking, muscle weakness, unsteadiness of feet, hypothyroidism, major depression, vitamin D deficiency, GERD (gastro-esophageal reflux disease) and displaced fracture of lateral end of the left clavicle. The EMR shows R1, while at the facility was in in the designated dementia unit. R1 was transferred to new room at 12:00PM 7/14/2023. R1's new room was located across the hallway from her previous room. Then, on 7/23/2023, (9 days after the reported physical attack from R11), R1 was moved to the first floor. R1 had verbalized to V9 (Social Service Director) she was afraid in the dementia unit where R11 resides. The MDS (Minimum Data Set) Assessment dated July 3, 2023, showed R1 required extensive assistance from staff for toilet use, transfers, ambulation inside/outside of her room, personal hygiene, eating, dressing, and bed mobility. R1's primary mode of locomotion was a wheelchair. The MDS shows R1 was assessed with having trouble in falling asleep, trouble concentrating on things, and she moves and speaks so slow it is noticeable to others. R1 was assessed with no negative behavior. The progress notes show R1 was alert, oriented and verbally responsive. R1 was noted with forgetfulness at times and periods of being impulsive and attempting to stand without asking for assistance. The facility provided Spanish speaking staff to educate R1 on asking for assistance in standing and mobility. On 8/7/2023 at 11:13 A.M. V3 (ADON/Assistant Director of Nursing) said that on 7/14/2023, around 7:30 A.M., V5(RN/Registered Nurse)	S9999		

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informed her R1 said she was attacked in the shared bathroom. This bathroom was used by both R1 and R11. V3 said after the daily meeting with the department managers including V1 (Administrator), V4 stated she informed team of R1's allegation of being physically attacked. V3 said she was told to just transfer R1 to the adjacent room. V3 said there was no abuse investigation started regarding R1's allegation of being physically attacked.

On 8/7/2023 at 12:15 P.M., V5 (Registered Nurse/RN) said his regular assignment is in the dementia unit as a full-time day nurse. V5 said he knows his residents well including R1 and R11. V5 said R1 had a "ritual of getting up from bed or wheelchair in her room and goes by herself to the bathroom shared with (R11)." V5 added R1 and R11 share the same bathroom. V5 said R1 was slow and would spend 25 to 30 minutes in the bathroom. V5 said R11 was demanding, very inpatient, easily frustrated, and angry. V5 added R11 is very territorial of the shared bathroom and her room. According to V5, R11 would get mad and yell at R1 for using the shared bathroom. V5 stated R11 would become angry and frustrated with R1 since R1 moved slow and spoke Spanish and little English.

V5 said on that 7/14/2023 at 7:00 A.M., R1 was sitting in her wheelchair in the dining room. V5 said it was the night shift staff that gets R1 up for breakfast. V5 said when R1 saw him, R1 started to wave her hand for V5 to come to her. As V5 approached R1, V5 said R1 told him, "I was pushed, kicked, and attacked by (R11) in the bathroom early this morning. (R11) attacked me for using the bathroom." V5 added though R1 speaks mostly Spanish, R1 speaks minimal English and with sign gestures, R1 was able to

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communicate. V5 said R1 was alert and knew what had happened. V5 said she immediately informed V3 (Assistant Director of Nursing) of the allegation of physical abuse V5 reported and stated a physical assessment was not completed on R1. V5 said during the time R1 was talking to him regarding being attacked by R11, V6 (CNA/Certified Nurse Assistant/Spanish speaking staff) came and heard what R1 reported to V5.

V5 said, "(R1) was very lucky she got away from (R11). (R11) was very inpatient, doesn't want others using the shared bathroom, pushes and yells and she will not wait for (R1) to be done using the bathroom. Maybe next time, (R1) won't be lucky to get away from her (R11). (R1) was a very frail, tiny, shy lady and (R11) was a large built, intimidating and a bully." V5 said around noon on 7/14/2023, he was told by V3 to move R1 to another room, which was just across the hall. V5 confirmed there were no in-services, no investigations done regarding the incident between R1 and R11. V5 said he was only asked about R1's unexplained bruise when there was a state surveyor in the facility on 7/24/2023. V5 said there was no special plan of care regarding monitoring of R1 and R11 after the incident. V5 added R11 acts out without provocation and is ambulatory and freely roams around the Dementia Unit. V5 said 27 residents on the unit are severely cognitively impaired and cannot verbalized their needs and are at risk for abuse from three residents (R11, R14 and R15) with psychiatric illnesses V5 stated the other residents are frail and have severely impaired cognition and are at risk for abuse.

On 8/7/2023 at 12:52 P.M., V6 (CNA) said he speaks Spanish fluently. V6 said he is regularly scheduled in the dementia unit for the day shift.

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S9999	Continued From page 6 V6 said he came to V5 and R1 on 7/14/2023 around 7:00 A.M. when R1 told V5 she was being attacked, pushed, and kicked by R11 in the shared bathroom during the early morning hours of 7/14/2023. V6 added he was not interviewed about the incident between R1 and R11 nor was he provided any training after the incident. Both V5 and V6 said R1 was reliable with her statement. While R1 was informing them what R11 did to her, R1 had pointed R11's permanent seat assignment in the dining room. V5 and V6 said R1, "The woman who always seat at the end of this table was the one who had hit me this morning." V5 and V6 had confirmed the woman R1 was referring to was R11. On 8/7/2023 at 1:34 P.M., V4 (Dementia Coordinator) said she was not aware of the physical altercations between R1 and R11. V4 added the facility initiated an investigation after notified by R1's family of the bruises noted on home visit 7/18/2023. V4 said R1's family took R1 home and found large bruises on R1's left shoulder, arm, forearm and R1 had difficulty raising her left arm. V4 said R1's family had called and reported to her about this unexplained injury/bruises on 7/18/2023 at 5:30 P.M. R1's family asked, "What happened to my mom? Why does she have big bruises on the left shoulder, left upper back shoulder, upper arm, left forearm and left side of her face (cheekbone)?" V4 said she immediately called V3, and they started an investigation regarding the unexplained bruises. V4 confirmed she was not aware of R1's allegation from 7/14/2023 and was unaware of any investigation. V4 confirmed R11's behaviors of being impatient, angry, and territorial which leads to anger towards other residents. V4 added R11 is very controlling about the shared	S9999		

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S9999	Continued From page 7 bathroom. V4 said R1's family had sent pictures of R1 when she was informed on 7/18/2023. V4 said R1's pictures showed huge yellowish-greenish bruises surrounding the left upper side of her body including shoulder, arm, and face. V4 said there was no special monitoring regarding R11's behavior after the incident. On 8/7/2023 at 1:08PM, V9 (Social Service Director) stated she did wellness checks on R1 after the family complaint of bruising. According to V9, R1 was still complaining of pain. On 8/7/2023 at 3:54 P.M., V17 (LPN, worked on 7/15/2023 for day and evening shift and on 7/16/2023 for the evening shift) said no report was given to him regarding the physical attack by R11 on R1, only the bruises when it was discovered by family on 7/18/2023. V17 said he was not asked for an investigation regarding these incidents. V17 said on 7/25/2023, sometime in the afternoon, he was asked to call for ambulance for (R11) to be taken to the hospital for evaluation. V17 stated he was not given a report on R11, just told to call for medical transport. According to V17 the ER (Emergency Room) nurse called about R11's behavior and R11 mentioned killing but the hospital was unsure if R11 meant herself or another person. R11 was transferred to a psychiatric hospital. There were no in-services received regarding this, no special monitoring for R11, just to check for side effects for the psychotropic medications given. V17 said R11 is always demanding and when staff does not give at once what she wanted, R11 will get angry and yell. V18 (LPN-Nurse), V19 (Nurse Aide), V20	S9999		

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(RN-Nurse) and V21 (LPN-Nurse) all work the Dementia Unit and were all interviewed about the incident between R1 and R11. V18, V19, V20 and V21 all stated they were not interviewed about the reported abuse between R1 and R11 and none of the staff was aware of R1's allegation. Staff was unaware of any behavior monitoring of or interventions for R11.

On 8/7/2023 at 4:33 P.M., V22 (CNA, worked on 7/18/2023 for day shift) said after lunch that day when she was getting R1 ready for a family visit, she noted a large bruise on R1's left shoulder, armpit, back and chest area. V22 stated the color was somewhat greenish yellow, like a fading bruise and R1 could not raise her arm. V22 stated she reported this to (V23, LPN).

V14 (LPN, worked 7/19/2023 evening shift) was interviewed on 8/7/2023 at 4:50PM and stated that on 7/19/2023 at 7:45 PM, R1 returned to the facility with her daughter. V14 said R1's family was very upset about what happened to R1. The family wanted to know what caused the large bruises on R1. V14 said she notified (V8, ANP-Nurse Practitioner) and an x-ray of the left shoulder was done. V14 said the result was an acute fracture of the left clavicle.

On 8/7/2023 at 3:31 P.M., V1 (Administrator) said the physical abuse on 7/14/2023 was not investigated. V1 added, "I heard something happened in the bathroom of (R1 and R11) but I did not think much about it, did not follow up on it, nor investigation was done. I should have investigated it, so I would have known the cause and to monitor (R1's) injury and (R11) monitoring for potentially taking advantage of other residents."

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S9999	Continued From page 9 The facility submitted an initial incident report to the department 7/18/2023 with a final report dated 7/20/2023. The report does not include R1's allegation of R11's physical abuse. The facility concluded, "the injury to the right clavicle was self-inflicted." R1's injury was to the left clavicle. The facility did not submit any investigation regarding R1's allegation of abuse by R11 nor was this information included in the incident report of 7/10/2023. On 8/7/2023 at 4:54 P.M., V8 (ANP-Advanced Practice Nurse) said she was informed on 7/19/2023 R1 had large bruises greenish yellowish in color around left armpit, left shoulder, arm and forearm. V8 said she had ordered an X-ray and the result was an acute fracture of the left clavicle. V8 said she examines R1 one to two times a week. V8 added R1, basically speaks Spanish but was able to verbalize her needs. Although R1 was forgetful, R1 was reliable with her statement. V8 said based on (R1's) injuries she sustained on the left side of her body, (R1) was correct when she said she was pushed by (R11) since (R11) was on R1's right side. V8 said, "You do not pull somebody toward you if you are upset, you push them away from you, this makes more sense that (R1) was pushed from her right side and landed on her left side, and it showed from her sustained injuries." V8 said the fracture was caused from a trauma, was not pathological and just did not happen on its own. On 8/7/2023 at 10:30 A.M. together with V2 (Director of Nursing), V3 (Assistant Director of Nursing), V4 (Dementia Care Coordinator), and V5 (RN-Nurse), the shared bathroom was noted with a handwashing porcelain sink next to the toilet. R1 was pushed from the right onto the sink which injured her left clavicle. R1 reported she	S9999		

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was "pushed" in the bathroom on 7/14/2023 causing the injuries to the left side of the body.

During this observation, R11 came rushing to her room and immediately went to the bathroom. R11 immediately closed bathroom door on R1's side, and then quickly closed and slammed bathroom door from her (R11's) side of her room. R11 did this very quickly as to be protecting her "territory" before the surveyor was able to get out of the bathroom. R11 said, "I need my privacy." The distance from R11's bathroom door to the toilet seat was 22 inches.

It was observed R11's roommate bed was empty. V4, and V5 said R13 was R11's roommate. V4 and V5 said R13 stays in the dining room all day, so it does not bother R11. R13 was observed sitting in her wheelchair in the dining room. R13 was leaning on the table, and she was asleep. Meantime, R12 was observed in bed, and said "I do not use the bathroom anyway, they just change my diaper."

The EMR shows R11 a 69-year-old female with diagnoses of schizophrenia, heart failure, unspecified dementia with unspecified severity, paranoid schizophrenia, pseudobulbar affect, other psychotic disorder, and paranoid schizophrenia. R11 was admitted originally admitted to the facility on 8/4/2022.

The care plan dated 8/17/2023 shows a history of maladaptive behavioral symptoms related to diagnosis of chronic mental illness, depressive disorder, and agitation. The 9/12/2022 care plan history shows R11 still expresses maladaptive behavioral symptoms related to diagnosis of chronic mental illness, a depressive disorder, agitated, and has been using unfriendly language

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to her other peers. R11 exhibits verbally abusive behavior when agitated. R11 will be verbally abusive, yell at others, make threats, swear, and make demeaning statements. In addition, R11 can become frustrated when others interfere with her daily routine. The care plan shows no specific interventions or plan of care to monitor and prevent aggressive behavior.

On 8/8/2023 at from 3:10 P.M. through 3:20 P.M., R11 was observed sitting in a regular chair in the dining room. There was a Bingo activity going on. V25 (Activity Aide) left the residents unsupervised including R11, who was seated elbow to elbow with another residents. V25 said no one told her of any monitoring regarding R11. V25 was not aware of the physical abuse occurred 7/14/2023. During this time, V22, V17 and V5 said R13 was only moved to another room today (8/8/23) in the morning. R11's door was closed at this time.

The facility's abuse policy dated 2/11/2011 shows: It is the policy of this facility to prevent resident from abuse, neglect, mistreatment, and misappropriation of property." The policy shows when an employee or agent becomes aware of abuse or neglect, the abuse policy and procedure should be implemented immediately. The policy shows for the protection of other residents, if the perpetuator is a resident, then this resident should be evaluated immediately to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. The policy shows any incident or allegation involving abuse or mistreatment will result in abuse investigation.

The undated facility policy for "Accident/Incident Reporting" shows " ...10. Documentation of the

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S9999	Continued From page 12 resident's physical and mental status will be completed each shift following a minimum of 72 hours." (A)	S9999		