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
	IL6000640	A. BUILDING: ______ B. WING ______	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DES PLAINES REHAB	9300 BALLARD ROAD DES PLAINES, IL 60016

(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 Complaint Investigation #2391216/IL156349 - F600 cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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care needs of the resident.

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)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to prevent a vulnerable resident from being the subject of physical abuse by an employee. This failure affected one (R4) of three residents reviewed for abuse and resulted in (R4) being mistreated while being provided with personal care from staff member.

Findings include:

R4 is a 62-year-old female who was admitted to the facility 1/27/22 with diagnoses that included Respiratory Failure, Tracheostomy, seizures, and history of Cardiac Arrest. MDS (Minimum Data Set) dated 1/14/23 notes that R4 had severely impaired cognition and required maximal assistance with all activities of daily living, was incontinent of bowel and bladder. R4 had a tracheostomy and was receiving full ventilator support.

R4's Care Plan was reviewed. Care Plan initiated 2/10/22 Focus: R4 presents with an alteration in ability to communicate related to: Impaired cognitive abilities, Impaired speech. R4 has a hx of Pulseless
Electrical Activity, Acute Saddle Pulmonary Embolism, and Ischemic Encephalopathy which

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could be affecting her cognitive abilities. R4 is also a trach/respiratory patient which could also be affecting her ability to speak.
Based on surveyor review, there was no care plan included to address R4's risk of abuse.

V2 Director of Nursing was interviewed 2/23/23 at 11:38AM and said, V4 was non-verbal, not responsive, and not able to track with her eyes at baseline. I helped with the allegation investigation regarding R4 and V17 CNA. The family came to the facility and asked to speak to management. She showed us a video where V17 lifted R4's head grabbing with one hand. V17 finished changing the resident and left the room.

V1 Administrator was interviewed on 2/23/22 at 11:38AM. V1 said, the family of R4 had a teddy camera in the room that we were not aware of. The daughter (Power of Attorney) for R4 brought it to our attention; a video that showed R4 getting care from V17 CNA. V17 explained that when making the attempt to lift the head, her hand slipped because she was only using one hand. We would have preferred for her to use two hands to lift the head from underneath but unfortunately, she didn't. I called the local police and added to the report, and they said that there was nothing for them to investigate because it didn't appear that there was anything criminal involved. Therefore, we didn't deem this as abuse. V17 was suspended immediately pending investigation and then we decided to terminate her for discourteous behavior.

Report obtained from Sheriff Police Department - Incident Report dated 4/13/22 documents:

V18 (Police Officer) responded to the above address for Assault service call later reclassified

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STREET ADDRESS, CITY, STATE, ZIP CODE: 9300 BALLARD ROAD, DES PLAINES, IL 60016

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S9999	Continued From page 3 to Suspicious Circumstances. Upon arrival V18 spoke with V1 (Administrator), who stated that this morning his staff removed a video camera from patients (R4) room. At approximately 1130Hrs (R4) family members arrived at the (facility). (R4's daughter) showed him a video where Staff member (V17) lifted (R4) head approximately 4-5 inches, pulled the pillow and did not place (R4) head back on the bed gently. (V1) stated (V17) might scooped or grabbed (R4) hair twice, video was unclear. (V1) said that Patient (R4) is comatose and brain dead, staff members performed head to toe physical and din not observed any signs of abuse. [sic.] (V1) stated that (V17) was suspended pending internal investigation and Illinois Department of Public health was notified via IDPH website (facility reported incident). (V1) said that he had a long conversation with (R4's) family members and explained that (V17) will be suspended pending investigation. Unable to interview (R4) due to her medical condition. Unable interview (V17), (V17) due to her not being on scene (suspended). Unable to interview family member (V20 Family Member) or watch the video of the incident. Supplemental Police Report dated 14-APR-2022 1835, completed by V18 (Police Officer) documents: In summary, (V18) responded to I.S.P. (Illinois State Police) and spoke with (V20 Family Member) who showed V19 (surveyor) the video footage that was taken in her mother's room located at (facility). V19 (surveyor) observed a female subject who was identified as (V17 CNA) adjusting (R4's) pillows and body positioning. While doing so she grabs the back of R4's head and raises her off the bed to a semi seated	S9999		

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position then roughly slams her head back onto the pillow, (V17) does this same motion twice to (R4). (V20) stated she is willing to sign Criminal Complaints against (V17). Surveyor advised (V20) to save any footage for further investigation. Nothing further.

V20 (Family Member) provided surveyor with video footage of interaction between V17 and R4 in question. Video was reviewed and surveyor confirms description provided in supplemental police report completed by V19 (Police Officer).

Facility provided investigation of incident which was reviewed.

V17's CNA personnel file was reviewed. Employee Disciplinary Action Form dated 4/13/23 noted V17 was suspended pending investigation of "Policy Violation."

Employee Disciplinary Action Form dated 4/18/23 noted, "After a thorough investigation, it was confirmed that the employee violated a category I offense, specifically, #27 Discourtesy to resident, family, or fellow employee. Employee was discourteous to a resident on 4/13/22. Employee is terminated effective immediately."

Facility provided Employee Standards of Conduct (No revision date) which states in part: This list is intended not be representative of the types of activities that may result in disciplinary action, up to and including termination- Rough handling or abuse of a resident. (Under heading) "Disciplinary Action" the document explains, "Category 1 offenses are most serious and subject to the employee's immediate discharge without rehire privileges. The following are Category 1 offenses: 1. Resident abuse (verbal or physical), or neglect;

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S9999	Continued From page 5 27. Discourtesy to the resident, families, or fellow employees." Facility Abuse Policy revised 1/2019, was reviewed and states in part; "As part of the social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis." (B)	S9999		