STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008072	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINGS MANOR RHC	502 NORTH MAIN BRIGHTON, IL 62012

(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 Investigation of Facility Reported Incident of 2-6-23/IL156464	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.3210t) 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to prevent employee to resident abuse for 2 of 3 residents (R1, R2) reviewed for abuse in the sample of 19. This failure resulted in V3 (Social Service Director) verbally abusing and forcibly restraining R2 causing R2 to cry out for help, become tearful, and become reserved after the initial incident. Findings include: 1. R2's February 2023 Physician Order Sheet (POS) documents R2 has a diagnosis of dementia with behavioral disturbances. R2's Minimum Data Set (MDS) dated 12/12/2023 documents R2 has long and short-term memory problems and is moderately impaired for decision making. R2's Care Plan with a start dated of 9/19/2022	S9999		

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S9999	Continued From page 2 documents, "Resident has behaviors that others may find disruptive/socially inappropriate. Other risk factors that may result in harm to resident: poor safety awareness. Communication: Problem, "Due to dementia Resident has decreased functional level of communication. Resident unable to express a concrete thought or idea." R2's Investigation of Possible neglect/abuse, dated 2/6/2023 (no time) documents, "Verbal and physical abuse/restraint of resident by staff member. Forcible restraint of resident to dining room chair and verbal abuse (screaming and yelling). See attached sheet. Results: Forcible restraint of resident in dining room chair and verbal abuse recognized and (V3) was terminated. Witnesses wrote statements regarding incident. (V3) indeed was found to have physically restrained resident and terminated. (V3) was suspended immediately after incident. After formal investigation by Administrator (myself), and police informed, (V3) was fired by the facility." R2's Final Incident Final Report documents, "On 02/06/2023 at 8:17 AM, it was reported that the Social Services Director, (V3/Social Service Director) spoke inappropriately to resident (R2) and physically placed resident into chair." On 2/14/2023 at 11:10 AM, V1 (Administrator) stated, "We had to fire (V3/Social Service Director). There was an allegation of abuse with (R2) on 2/6/2023 and it was substantiated so we had to fire (V3). (V3) no longer works in the facility." On 2/14/2023 at 11:17 AM, V2 (Director of Nursing/DON) stated, "(V3) was verbally	S9999		

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S9999	Continued From page 3 aggressive with (R2) and she slammed (R2) into her chair and held her there in a bear hug. We had to do an investigation and (V3) was terminated." On 2/14/2023 at 3:31 PM, V1 stated, "I am not aware of any other instances when (V3) lost her temper." V3 stated that they assured R2 that V3 would no longer be taking care or R2V3 stated "She was shook [sic] up and her family is pressing charges against (V3)." On 2/14/2023 at 3:44 PM, V11 (Power of Attorney/POA) of R2, stated, "The day the incident happened (R2) made comments; she kept saying someone grabbed her, and he had put her in a choke hold and was holding her down. She was crying and upset about it. Because of her dementia I am not sure how much she remembers now, but she remembers that day and it was upsetting to her. We are pressing charges against the Social Service Director."	S9999		
	On 2/15/2023 at 10:03 AM, V5 (Unit Aide) stated, "I was working when (V3) attacked (R2). I usually take care of (R2), and she is confused but very sweet. I was setting the table and (R2) is not supposed to have a knife. When she sat down, I saw that she had a knife and I was trying to take the knife away. Then (R2) grabbed (R4's) knife and (R2) was upset with me because she wanted the knife and she is not supposed to have a knife. (R2) was getting frustrated and started screaming, 'leave me alone' and (V10/Licensed Practical Nurse/LPN) was assisting me when (V3) came out of the office running and started screaming at (R2). It happened so fast and unexpected. (V3) pushed (R2) into her chair and put her in a choke hold and (R2) was screaming,			

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S9999	Continued From page 4 'Help me, 'help me!' and (V3) was screaming back at (R2) and cussing at her and holding her down. It was awful. I could tell (R2) was scared and after the incident (R2) even though she has dementia she became really quiet that day and reserved all day long. (R2) would not talk to me and that is not normal because she always talks to me. I think at that moment she was just scared, and it traumatized her for the next few hours. We should never treat residents the way (V3) acted. I think (R2) was in shock after it happened. Then a little later (V3) walked past me and said, 'I got suspended because of that b****.' I just avoided eye contact with her because it was just not right what she did. (V3) never liked (R2) and she crossed a line with (R2)." On 2/15/2023 at 10:32 AM, V8 (Certified Nursing Assistant/CNA) stated, "I remember that day as I was working in the dining room and (V5) was trying to get (R2) to sit down and (R2) was upset about wanting to have a knife and (V5) was trying to calm her down and (V3) came out of her office running and started yelling at (R2) telling her she can't yell at her staff. (R2) is very confused and she does not really know what she is doing half of the time. (V3) slammed (R2) down in the chair and put her in a choke hold, her right arm around her waist holding her in the chair and her left arm around the top portion of her body pressing her to the chair. I am just a CNA, and I was shocked because it happened so fast. I knew it was not right. (V3) was screaming at (R2) and (R2) was crying and yelling out 'Help me, help me!' (V3) was screaming at her and then (V3) let her go and went back in the office. We were all shocked and poor (R2) ...she just got really quiet and reserved and that was not like her. I am not sure if she remembers it now, but that day (R2) was shook [sic] up."	S9999		

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S9999	Continued From page 5 On 2/15/2023 at 11:45 AM, R2 stated, "I remember that woman that held me down and hurt me, but she does not work here anymore." An undated statement from V6 (LPN) documents, "During second seating (R2) was wandering around dining room, staff member, (V5, Unit Aide), was redirecting back to her table. (R2) was upset with (V5), but the two had no real issues at that time. (V3) started screaming at (R2) using her arms to corral and push her towards her chair. (V3's) screaming was very loud, threatening and escalated. (V3) then threw R2 backwards into her chair while still screaming at her, (R2) was clearly upset. (V3) came from behind chair and had her left arm around (R2) up under her neck and her right arm pinning (R2's) arms to her side. When (V3) realized the entire dining room was clearly upset by her behavior she let go of (R2) and walked to the front office area." An undated statement from V5 (Unit Aide) documents, "I was down in the dining room getting everything set up for breakfast. I was helping get the residents down. I got (R2) to the dining room, forgot that I had left a butter knife in her silverware. So, when I noticed I went and took it from her. She was mad at me. She then went to (R4's) table and got her silverware. I had to take the knife from her there. So, she was upset with me. She then yelled at me 'Leave me alone.' That's just normal for (R2) for me. (V3) then ran into the dining room yelling 'You won't talk and treat my staff like that!', then was pushing (R2) to her seat and shoving her. She (V3) then threw her in her chair and held her down. (R2) was screaming. She had her arms around her neck and was making her tied to her chair. After (V3)	S9999		

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S9999	Continued From page 6 was called into the office, I was charting, and she (V3) looked at me and told me 'I got suspended because of that b****.'" An undated statement from V9 (Registered Nurse/RN) documents, "I was in my office and heard a noise in the dining room. When I looked up, I saw (V3) screaming at resident (R2). She (V3) then grabbed her and put her arm across her chest and pushed her in the chair. (R2) then swung and hit (V3) in her face." An undated statement from V8 (CNA) documents, "I was down in the dining room feeding a resident, when I noticed (V3) slammed a resident down in the chair and had her left arm around her neck and her right arm wrapped around her body." An undated statement from V9 (Business Office Manager/BOM) documents, "On Monday, February 6th at about 8:30 am I was sitting in my office up front, and I heard (V3) yelling in the dining room. (V3) was yelling at (R2) telling her to sit down and she needs to leave her staff alone. (V3) came through the front hall door yelling 'I'm going to knock her ass out.' (V3) was also saying 'that b**** needs to go' and that she could not stand that b****."' An undated statement from V10 (LPN) documents, "Resident was yelling at (V5) for taking knife from her. (V3) walked into the dining room very loudly yelling '(R2), you need to sit down and eat! You're not going to yell at my staff.' (R2) continued to yell back, while (V3) lead her to her chair. Both yelling at each other. I had looked away but heard commotion, looked back as (R2) swung at (V3), unsure if she made contact and (V3) then bear hugged her very forcefully. (V3)	S9999		

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S9999	Continued From page 7	S9999		

said 'Now sit your ass down and eat your food! You aren't going to yell at me!' (V3) then left the dining room. After (V3) was called into the office, she came out and said, 'I just got suspended cause of this b****.'"

An undated statement from V3 documents, "I was in the ADON's (Assistant Director of Nursing) office when I heard (R2) scream in (V5's) face. I went out to assist her. I told (R2) she wasn't gonna scream at my staff. I then guided her with my arms open to her seat. She wouldn't sit down. I pushed the chair right up behind her and pulled her by her waist to get her to sit. I said, 'Sit your ass down!' I know I shouldn't have said it, but it was too late. When she sat, she swung her right arm at me and hit me in my left cheek. It frustrated me and I bear hugged her and said, 'You're not going to hit me!' She screamed at me. I don't remember what she said. I then let her go because I was very angry and already upset on how I handled the situation. There were witnesses: (V5), (V8), (V6), (V10), (V7) and I'm not sure if dietary staff witnessed it. I immediately went to the BOM (Business Office Manager) office to vent and get away from the situation."

An undated statement by V1 (Administrator) documents, "Interviewed all witnesses listed and asked why when incident happened no one intervened, and the consensus of the witness accounts was that 'It happened so quickly that it was over before we could react.' (V3) realized what she had done and immediately removed herself from room."

R2's Police Report dated 2/7/2023 at 9:35 AM, "On 2/6/2023 at approximately 12:14 AM, (V2) called (police) and left a voice message to come to facility because they need to report an incident

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S9999	Continued From page 8	S9999		

that occurred. At approximately 1:55 PM, I (V18/Local Police Sergeant) went to (Facility) and met with (V1) and (V2) about an incident that occurred. (V1) and (V2) both stated this morning around 8:20 AM, it was reported to them that staff member (V3) got upset with resident (R2) because (R2) was screaming at staff member (V5). (V1) and (V2) stated (R2) screaming at (V5) upset (V3) who responded by coming out of the office and screaming at (R2) telling her not scream at her staff member and force-ably pushed (R2) in the chair and wrapped her up in a bear hug with (R2's) arms wrapped around her neck. (V1) stated (R2) was checked out and did not have any marks or injuries. (V2) stated (R2) is a resident of (Facility) and suffers from dementia. (V1) obtained written statements from staff members (V5), (V10), (V7), (V6), (V8), and (V9) which were all consistent with the incident that took place. (V1) stated (R2's) POA (V11) was notified of the incident. (V1) stated she sent (V3) home for the day. End of conversations. I called and spoke with (V11) who stated (Facility) did call and report the incident to her. I asked (V11) if she would like to pursue charges. (V11) stated yes. V11 signed non-traffic #0611. I called (V3) to see if she could come to the (Police Department) to speak about the incident. (V3) agreed and stated she would come in around 3:00 PM. No further actions were taken, nothing further to investigate. On 2/6/2023 at approximately 3:29 PM, I (V18) conducted an interview with (V3) at the Police Department. (V3) was given her Miranda Rights and agreed to speak with me. (See Miranda Rights Form). 2/14/2023 at 3:26 PM, The following is a synopsis of the interview with (V3) and not verbatim. (V3) stated she was in the office with (V7) when heard (R2) yelling at the top of her lungs, 'leave me alone' or 'stop' because someone was trying to talk to her about sitting

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S9999	Continued From page 9 down. (V3) stated it was breakfast time. (V3) stated she walked up to (R2) and said, 'You are not going to yell at staff like that. You need to sit down and eat.' (V3) stated (R2) has really bad dementia. (V3) stated (R2) tried to push through her and (V3) tried to corral (R2) with her arms open wide to get her to sit down. (V3) stated she thought she then told (R2) to 'Sit you ass down' and pulled her into the chair by grabbing onto the rear of her pants. (V3) sated (R2) then bopped her in the face with her right hand. (V3) stated she then placed her arms around (R2) in a 'bear hug' and told (R2) 'You're not going to hit me. (V3) stated she then let go of (R2) and went up front to vent to her co-workers. End of interview. I issued (V3) Non-traffic Complaint for the charge of Aggravated Battery and explained the court date." 2. R1's February 2023 POS documents diagnoses of Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Severe Coronary Artery Disease (CAD) and Anxiety. R1's Minimum Data Set (MDS) dated 2/8/2023 document she is severely impaired for cognition. R1's Initial Report sent to Illinois Department of Public Health (IDPH), dated 2/13/22, documents "A staff member was witnessed speaking inappropriately to a resident. Staff member immediately suspended. Investigation initiated with final to follow." On 2/14/2023 at 11:10 AM, V1 (Administrator) stated, "This allegation of (R1) verbal abuse just occurred Sunday. I am still investigating. I have interviewed the resident and have talked with a couple of staff members." On 2/14/2023 at 11:10 AM R7 stated this is a very	S9999		

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S9999	Continued From page 10 nice facility, especially since they got rid of a problem, one certain CNA who was very mean to some of the residents. R7 stated (V4/CNA) would talk and act mean to some of residents she took care of. On 2/15/2023 at 3:28 PM, V21 (LPN) stated, "(V20/CNA) and (V19/CNA) came to me on 2/12/2023 (Sunday) and told me (V4/CNA) had screamed in (R1's) face and told (R1) she hated her. I, personally, did not witness anything. They were in the process of contacting the administration as they were telling me. I know they called (V1) and told her of an abuse allegation of (V4) and (R1). This was around 4:30 PM. (V4) continued to work in the facility until around 7:30/8:00 PM after the evening meal. (V1) called me later and told me to send (V4) home, which I handed her (V4) the phone and then she left a little after 8 PM." A statement dated 2/12/2023 from V20 (CNA) documents. "At 4:15 PM, I (V20) saw (V4/CNA) verbally abuse (R1) by mocking recent behaviors (R1) has had, for example crying and whining in her face, telling her (R1) that's why she (V4) stays away from her (R1) because she don't like her (R1) and telling her all she does is cry and say 'I want to kill myself' and stared at (R1) and continued to stare at her in silence and also whispered something I could not hear." On 2/15/2023 at 3:46 PM, V20 (CNA) stated, "We (V19/CNA) and I were standing in the hallway. Then (V4) came up to my resident (R1) and started mocking her, saying stuff like 'Waa Waa Waa' like a baby and telling her (R1) really close to her face that 'I don't like you.' This all happened approximately at 4:15 PM. I immediately reported it to (V1). (V1) told me to	S9999		

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S9999	Continued From page 11 make a statement and put it under her door. (V4) continued to work. (R1) started stuttering and I could tell it really upset her because she would not even eat later that night. (R1) is very confused, so I am not sure she could even tell you today what happened. But at the time I know it bothered her and upset her." A statement, dated 2/12/23, by V19 documents, "On 2/12/2023, I, (V19), witnessed (V4) verbally abuse resident (R1) around 4:15 PM. (V20) and I were outside of (R1's) room when I heard (V4) tell (R1) that she doesn't like her, that is why she stays away from her; and all she does is whine all day and say she is going to kill herself. Then (V4) continues to stare at (R1) and make baby like sounds in (R1's) face. (V4) then continued to stare at (R1) and said some things I could not hear." On 2/15/2023 at 4:14 PM, V19 stated, "(R1) had just had a fall and there was a lot of commotion going on. (V21) was over by the medication cart and (V20) and I were standing in the hallway. (V4) comes up to (R1) and gets really close to her face and tells her, 'I don't like you.' (V4) then starts to make baby sounds, 'Waa Waa Waa' and starts staring at her in a very intimidating way. Then she said something softer, but I did not hear what she said. I think she sees us looking at her. It was not right so I reported it to the administrator. (R1) seemed upset after she did that." On 2/16/2023 at 4:45 PM, V1 stated, "I am not finished with my investigation but at this point we had other residents tell us they have witnessed (V4) mistreating residents and we substantiated the allegation of abuse and terminated (V4) today."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008072	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINGS MANOR RHC	502 NORTH MAIN BRIGHTON, IL 62012

(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
S9999	Continued From page 12 The Facility Abuse Policy with a revision date of March 2022 documents, "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect, or abuse. This will be done by: Training on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property. Dementia management and resident abuse prevention. Procedures for reporting of potential incidents of abuse, neglect, exploitation, or the misappropriation of resident property. This facility is committed to protecting our resident from abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individual." (B)	S9999		