STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 FRI of 4/28/2023/IL159815 & Complaint Survey 2363756/IL159525	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure three of four residents (R1, R4, R5) were not subjected to physical and verbal abuse from another resident (R3) who were reviewed for abuse on the sample list of six. This failure resulted in R1 becoming fearful of R1's safety while at the facility because of R3's physically attacking R1 when R1 is bedbound and unable to defend R1's self. Findings Include: The facility Resident Care Policy and Procedure Regarding Abuse and Neglect, Involuntary Seclusion, Exploitation, Misappropriation of Resident Property, Injuries of Unknown Origin and Social Media dated 3/15/18 documents the following: All residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, and exploitation. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful as used in this definition of abuse means the individual must have acted	S9999		

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deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse means the infliction of injury on a resident that occurs, other than by accidental means and the required (whether or not given) medical attention. Physical abuse may include, but is not limited to such acts as: hitting, slapping, kicking, hair pulling and pinching. Verbal abuse means the use by an employee or agent or oral, written or gestured language that includes disparaging and derogatory terms to a resident or within his or her hearing or seeing distance, regardless of the resident's age, ability to comprehend or disability.

1.) On 5/15/23 at 10:10 am, R1's room door had two stop signs adhered on it. R1 was lying in bed and stated R1 has been "attacked" by R3 who has dementia, while here at the facility. R1 explained R3 used to come into R1's room quiet a bit and when R1 would ask R3 what R3's name is and what R3 wanted, R3 would say "Oh, you know who I am", then several months back, R3 came in and started hitting R1. R1 stated R1 reported it and it was already investigated by the facility and IDPH (Illinois Department of Public Health). R1 stated R1 hadn't had any other problems with R3 until a couple of weeks ago. At this point, R1 started to cry and explained, R3 wheeled R3's self into R1's room again and when R1 told R3 to leave, after activating the call light, R3 started pinching R1's right leg, to the point R3 broke the skin. R1 stated R1 tried pushing R3 away and kicking at R3 but "that leg doesn't work right, I (R1) have a spacer in that knee and I'm not able to bend it or really even move it, I"m pretty much bed bound." R1 stated staff responded to the call light and R1's yells for help and got R3 out of R1's room and R3 hasn't been back since. R1 started to cry again and stated, R1 "don't feel safe in the facility with (R3) also

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being at the facility and close to me (R1)" {R3 residents right across the hall from R1}, "I'm scare of what (R3) will do next." R1 went on to say, R3 has already attached R1 twice and R1 can't defend R1's self so now R1 has a spray bottle, pointing to a green spray bottle sitting on the over bed table and stated if R3 comes back in here and staff don't respond quickly, R1 can spray R3 with it to try and get R3 to go away; and if that doesn't work, "I (R1) have an extending fly swatter that I can use to try it and "shoo (R3) away with"." R1 explained R1 doesn't want to have to use them but that is the only way R1 can defend R1's self. R1 also stated the one time that R1 has come out of R1's room since the "attach" was for a care plan meeting and on R1's way back to R1's room, R1 noticed R3 sitting next to the nurses stated. R1 explained, "I (R1) started to panic when I (R1) seen (R3). I (R1) tried going quickly past (R3) and even turned my head so (R3) didn't see my face. I (R1) didn't want (R3) to follow me back to my room."

R1's MDS (Minimum Data Set) dated 4/15/23 documents R1 is alert and oriented.

R3's MDS dated 4/5/23 documents R3 has severely impaired cognition.

The facility's final abuse investigation between R1 and R3 dated 4/25/23 documents R1 stated R3 came into R1's room and requested to be covered up with a blanket and began pinching R1's leg. R1 stated R1 asked R3 to stop and then put on R1's call light. V15 CNA (Certified Nursing Assistant) responded to R1's call light after hearing R1 yelling and removed R3 from the room. At the time V15 responded, R3 was not doing anything but R1 stated R1 was pinched by R3. R3 does not recall the incident due to R3's

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diagnoses. The facility believes the allegation is substantiated.

On 5/15/23 at 1:16 pm, V1 Administrator confirmed R1 has been in an abusive situation while at the facility, more than once, but thinks R1 is confused and that the first situation was not with R1.

2.) The facility's final Abuse Investigation dated 5/7/23 between R3 and R4 documents V17 Housekeeping/Laundry Supervisor witnessed R3 hitting R4 closed fisted with the bottom of R3's hand on R4's arm. When V17 asked R3 "what are you doing", R3 then grabbed R4's arms. V18 CNA (Certified Nursing Assistant) also witnessed R3 grabbing R4's arm. Upon completion of the investigation, the facility believes the incident did occur as a result of R3's diagnoses.

R3's ongoing Diagnoses List documents R3 has Unspecified Psychosis, Dementia with Behaviors, and Delusional Disorder.

R3's MDS (Minimum Data Set) dated 4/5/23 documents R3 has severely impaired cognition.

R4's MDS dated 4/29/23 documents R4 has severely impaired cognition.

On 5/16/23 at 9:09 am, V17 stated V17 was coming upstairs from laundry and walked into the east wing lounge area. V17 witnessed R3 hitting R4. V17 stated V17 looked around to see if there was any staff around and there wasn't, so V17 went up to R3 and talked to R3 and rubbed R3's hand trying to calm R3 down and at that time, R3 stopped hitting R4's arm but then tightly grabbed R4's arm. At that point, an unidentified staff member came around the corner, so V17 asked

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the unidentified staff to take R3 away from R4. The two residents were separated and V17 asked R4 if R4 was okay and R4 replied, "yeah, (R3) better be glad that (R3) is a lady." R3 was still "irate" and trying to grab and hit everyone in R3's reach.

On 5/16/23 at 1:15 pm, V1 Administrator stated V1 watched video surveillance of the alleged abuse and the video showed R3 was sitting behind R4 in the lobby area. R3 rolled up to R4, R3 said something, you could see R3's mouth moving but not able to hear anything and then R4 said something back to R3. R4 "looked upset" and after R4 responded, R3 grabbed R4's arm and started pinching at R4. R3's hand was holding onto R4's arm and then pinching R4's torso area. Then I seen R4 moving R4's arm trying to get it away from R3 and trying to push R3 away. That went on for about 20 seconds then V17 and V18 came into the lobby area and they both separated R3 and R4. V18 moved R3 closer to the nurses station, and V17 was talking to R4. R3 was still upset, and reaching out trying to pinch a staff member that was walking by. Confirmed physical abuse occurred.

3.) On 5/15/23 at 9:50 am, R5 was sitting up in a recliner in R5's room and stated a couple of weeks ago, R5 was asleep in R5's wheelchair in R5's room, with R5's back facing the door when R5 was awoken by someone hitting R5 upside the back of the head and cussing at R5. R5 stated, R5 don't know who it was because they were behind R5 but R5 yelled out, "why did you just hit me" and several people came to R5's room. R5 reported staff said said it was a female resident, "they told me her name but I don't remember who it was but they got her out of here." R5 stated, "I (R5) don't know why they

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S9999	Continued From page 6 {facility} are making such a big deal about it, but then again, I guess people can't just go around and hit others. I (R5) just don't understand why she was cussing at me, I don't cuss so I don't appreciate her cussing at me." R5's Final Abuse Investigation dated 5/3/23 documents R5 reports that R3 smacked the back of R5's head. R5 has a BIMS (Brief Interview for Mental Status) score of 15 {indicating R5 is alert and oriented} and stated that R3 who has a BIMS of 4 {indicating severe cognitive impairments} came into R5's room while R5 was resting in R5's wheelchair and smacked R5 on the back of the head. During medication pass around 2100, V10 RN (Registered Nurse) went into R5's room and saw R3 in R5's room. V10 removed R3 and during that time, R5 reported that R3 smacked R5 on the back of R5's head. The facility believes the incident did occur as a result of R3's diagnoses. On 5/15/23 at 1:02 pm, V1 Administrator confirmed R3 verbally and physically abused R5. (B)	S9999		