STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003008	A. BUILDING: _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF BERWYN, THE	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

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S 000	Initial Comments FRI of 4/28/2023\IL159573	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 resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 interview and record review, the facility failed to protect a cognitively impaired resident from physical abuse from another resident with history of violent/criminal behavior. This failure affected one (R9) of 5 residents reviewed for abuse from the sampleof 29 residents.. This failure resulted in R9 falling to the ground after being violently pushed/assaulted by R10. R9 was emergently transferred to the hospital for her injuries of a femur fracture and with required pain management and surgical intervention. Findings include: R9 is a 66 year old resident with diagnoses listed in part with mild cognitive impairment, heart disease, hypertension, and fracture of the femur. R9's care plan dated 2/11/23 reads, "Presence of abuse and neglect factors. The resident presents with a difficult or troubled past secondary to severe mental illness. (R9) presents with risk factors related to acting as a recipient or perpetrator of mistreatment and/or neglect, exploitation, psychiatric history and present mental health symptoms. The resident presents with behavioral symptoms including: (not listed) and may minimize his/her/my mental health and	S9999		

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S9999	Continued From page 2	S9999		

psychosocial issues. Goal: The resident will be treated with respect, dignity and reside in the facility free of mistreatment. Interventions: Conduct appropriate assessments to promote knowledge and understanding of the resident's past; Provide reassurance to the resident reminded him/her that he/she is safe and secure."

On 5/22/23 at 11:50 AM, R9 was interviewed in her room and asked what happened to her, R9 stated, "I was attacked by someone, I don't know who did it." Surveyor asked how she was feeling, R9 stated, "I'm tired and want to get out the heck out of here. Can you take me home?" Surveyor asked whether she could recall how she was hit, R9 stated, "It was somebody out there (pointing outside the door)."

R10's care plan dated 12/29/22 reads, in all caps: "HISTORY OF CRIMINAL BEHAVIOR / IDENTIFIED OFFENDER. The resident has a history of criminal behavior. The resident has demonstrated stability during the admission screening process, does not appear to present an unusual risk, and is therefore considered appropriate for admission. Has been arrested and convicted of a crime(s): Criminal Trespass to vehicle in 2001. She is identified as moderate risk. The resident will behave in a safe manner consistent with resident conduct policies through the next review. Refer the resident to a mental health professional including a consulting psychiatrist for evaluation if the resident's symptoms warrant further assessment and/or on-going management. Refer the resident for psychotherapy, as indicated. Give psycho-active medication as ordered. Record behavioral symptoms and side effects."

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S9999	Continued From page 3 Hospital records for R10 from the most recent hospitalization dated 7/27/22 reads in part, "(R10) Patient with what appears to be stepwise decline in ADLs, in addition to increasing mood lability and behavioral agitation concerning for safety of self or others. Some of the behaviors noted by family prior to admission include run into traffic, running out of the apartment building, or posturing were making verbal threats when she "does not get what she wants". During the hospitalization, patient with new baseline of significant aphasia and dysarthric speech with short phrases only.She is fixated on food and needs frequent toileting. She has significantly low threshold for agitation, and has had multiple episodes of behavioral disturbances such as running out of the room, screaming without apparent needs. She also declined care from primary team such as obtaining vitals or necessary labs/imaging. She was initially also difficult to redirect, requiring multiple as needed's that psychiatry had recommended for agitation, requiring vest restraint and security presence." Facility reported incident dated 4/22/23 written by V1 (administrator) shows in part "(R9) walked into (R10) room and (R10) allegedly pushed her. Resident sent out for evaluation. MD and family notified. V3 (Agency LPN) wrote in a statement on the report: "(R9) was leaving out of another resident's room and proceeded to walk in the hallway and fell. She fell on her left side. After assessing her, she complained of pain on her left elbow. She denied pain in any other part of body. I called 911 to send her to hospital for evaluation. Vitals were stable when paramedic left the facility."	S9999		

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S9999	Continued From page 4 Interview with V3 (Agency LPN) on 5/14/23 at 2:00 PM stated, "I didn't really see the actual fall happen, I just saw her already on the ground. " Surveyor asked again to clarify whether she witnessed the altercation between the two residents, V3 stated, "I did not." Surveyor asked whether R10 had any history of violent behavior or whether R9 and R10 should have been monitored, V3 stated, "No one told me anything about either of these residents. I don't normally work there, I'm agency and I haven't worked back there ever since that incident." Progress notes written by V3 (Agency LPN) on 4/22/23 at 7:17 PM contradicts her interview and written statement and reads, "Patient was in another residents room when resident pushed patient in back to get her out of her room. Patient landed on knees then laid on floor and turned her left arm while laying on floor and sustained abrasion to left elbow, cleaned and dry, bandaged. Patient states she wants to go to hospital says she cant get up off the floor. 911 called. en route. vital signs. Paramedics here, transporting to hospital ER follow up with admit diagnosis." Progress notes written by V37 (agency LPN) on 4/25/23, reads in part, "6:10 PM, Patient was transferred from hospital by ambulance via stretcher. Patient is a 66 year old female with past medical history: CAD, hypertension, type 2 diabetes, dementia, and recurrent urinary tract infection. Patient had a fall which she was admitted with acute mild displaced intertrochanteric fracture of proximal left femur. Patient noted with 5 staples intact to left femur and 4 more staples going down 2 centimeters to left hip."	S9999		

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S9999	Continued From page 5 On 4/22/2023 at 14:29, V23 (Social Service Director) wrote, "Social Service Note. Writer was made aware that (R10) became physically aggressive with peer (R9) when they wandered into her room. Writer met with her to counsel her on appropriate ways of dealing with issues. (R10) She expressed understanding. Staff will continue to monitor for aggression." V3 (Agency LPN) wrote in her statement to the facility "(R9) was leaving out of another resident's room and proceeded to walk in the hallway and fell. She fell on her left side. After assessing her, she complained of pain on her left elbow. She denied pain in any other part of body. I called 911 to send her to hospital for evaluation. Vitals were stable when paramedic left the facility." Interview with V3 (Agency LPN) on 5/14/23 at 2:00 PM stated, "I didn't really see the altercation or actual fall happen, I just saw her already on the ground. " Surveyor asked again to clarify whether she witnessed the altercation between the two residents, V3 stated, "I did not." R9's hospital records shows in part: "Date of admission: 4/22/23. (R9) is a 66 year old female with primary medical history of CAD, hypertension, type 2 diabetes, dementia, who presented from the facility after a fall. History obtained from nurse at facility, son at bedside and patient. Patient reports that she had a fall and hence was brought to the Emergency Department. Per son, patient has history of multiple falls and she was walking when she had a fall. She denies hitting her head, but after the fall complained of left hip pain and hence brought here. Emergency Department course: X-Ray of hip showed intertrochanteric fracture of proximal left femur. Underwent open reduction and internal	S9999		

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S9999	Continued From page 6 fixation of left hip fracture with cephalomedullary nail. Day 1 post op, on physical exam left lower extremity is edematous and tender." Facility policy titled Abuse and Neglect dated 10/24/22 reads in part: "Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. 1. Physical: Physical abuse includes but not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, and roughly handling. Any person in a position of power or authority may potentially cause harm to a resident. Potential aggressors include but are not limited to, facility staff, other residents, state employers, family members, volunteers, students in an affiliated Nurse-training Program, students in affiliated academic institutions including therapy, social, and activity programs, guardian and other visitors. The general examples of physical altercations below illustrate possible cases that would likely NOT need to be reported, as long as it is not a willful action that results in physical injury, mental anguish, or pain per the new SOM: A resident lightly taps another resident to stop an irritating behavior or get attention, with no resulting physical injury, mental anguish, or pain. A resident who is slow, impedes the pathway of another resident, such as in the dining room, the other resident nudges the resident out of the way	S9999		

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S9999	Continued From page 7 to get to his/her table faster, but there is no harm to the victim. A resident who swats at another resident who is trying to take some food off his/her plate, and no physical injury, mental anguish, or pain has occurred." (A)	S9999		