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	IL6008270	A. BUILDING: _____ B. WING _____	C 01/11/2024

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S 000	Initial Comments Complaint Investigation 2490126/IL168420	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	S9999		

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal 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 requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their abuse prevention policy and procedures by failing to protect 1 of 3 residents (R1) in the sample from abuse by a staff member. This failure resulted in R1 being pushed to the bed, forcibly restrained, and roughly suctioned by a respiratory therapist (V3) after a physical struggle. This failure also led to R1 expressing fear, anger, and frustration with facility for not preventing further contact with this staff member after the resident reported the incident to his nurse and family member. Findings include: R1 is an alert and oriented 62-year-old with diagnosis of tracheotomy, gastrostomy, acute and chronic respiratory failure with hypoxia, and alcoholic liver disease. On 1/5/24 at 11:45 AM, R1 was observed in bed watching television, appeared alert and oriented, able to recall events of an incident, and able to respond to questions appropriately when asked.	S9999		

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S9999	Continued From page 2 R1 stated that he was slapped by a respiratory therapist while he was being suctioned around Christmas time and that it happened on two separate occasions. R1 indicated he ignored the first time it had occurred but could not ignore the second time because he realized it was now done on purpose. R1 then appeared distraught and became emotional when describing the events that occurred and added that the respiratory therapist pushed him on the bed and fought with him to get a tube down his throat. Surveyor tried to calm the resident and asked the resident if he was able to write the events down on paper, so he didn't have to struggle to talk through his trachea. R1 wrote on a piece of paper a similar statement he made with the surveyor that the respiratory therapist slapped him for coughing two times and that he told a nurse supervisor the next day. R1 added on this statement that he saw the respiratory therapist the next day and proceeding days thereafter and that he did not feel safe when he saw him." 1/5/24 at 12:30 PM, V1 Administrator stated, "The incident was reported to me on Christmas day around 3 PM but the incident happened on Christmas eve. I interviewed V3 (Respiratory Therapist) on Christmas day over the phone and I suspended him that day. It was reported that V3-respiratory therapist was standing on the left-hand side of the bed and the resident coughed and mucus came out and that the respiratory therapist slapped him on the face. I asked him to describe the employee and R1 said he was tall with long straight white hair. He did identify him as V3. Every time I spoke with (R1) he told me the same story, so it was consistent. The only thing that changed was that was that it was the left side of the face, not the right. I spoke with his sister, and she requested that he (V3) not	S9999		

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take care of the resident again, but I explained to her that if something happened, and that the resident needed care, that two people would come in just in case if it was an emergency." Surveyor asked why nurses or other staff couldn't respond to the emergency, V1 had no response except to say, "We always have two respiratory therapists at night." Surveyor asked how she ensured that V3 never came into R1's room at night since there is no supervisor at night and the respiratory office is on the same floor close to R1's room, V1 stated, " To my knowledge V3 has not come in to service (R1)."

On 1/5/24 at 2:20 PM, V3-Respiratory Therapist came to the facility to be interviewed by the surveyor. The VP of Clinical Operations (V 4) was requested to be present in the room. V3 stated, " Everybody knows that since he has been here (referring to the resident) he's been giving a hard time to all the staff, nurses, staff CNA's. He is refusing everything as far as respiratory care is concerned. He is totally refusing suctioning and in short, he doesn't like to be bothered. Sometimes he's in good mood then he will let you suction him. Everybody knows this. I reported to V11(Respiratory Director) and when I reported it to her, she said try to make the best and don't force him. Also, he just doesn't cooperate. He fights and wants me to suction him while you are standing. That's not easy and he wants to lie down in bed. It has happened 2-3 times. I tried to get him in bed. He was standing so I had to push him to the bed. I struggled with him to put him in bed for his safety. I pushed him to bed and struggled and he still wanted to get up, so I had to hold him down and check his saturation." Surveyor asked if he asked for any assistance, V3 stated, " I did not get any help. I suctioned him a little bit, he was very mad, and he was pulling

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my gown repeatedly and he was trying to push me away. I was trying to hold his hand and I pushed his hand away from my lab coat. I finished suctioning and tried to check his oxygen saturation. He coughed when he was lying down and when he coughed out his phlegm, I turned my face. I never touched his face when he coughed." Surveyor asked if he should have returned later when the resident calmed down, V3 stated, "No, I struggled with him and he's stronger than me. I even told the administrator that I struggled with the man and that I was upset about the whole thing." Surveyor asked V3 how upset it made him, V3 stated, "I was a little upset, but then I got very upset because I couldn't suction him thoroughly. He constantly fought me. I told the patient care tech and the nurse at the station as soon as I left the room, I told them to watch for that guy, he is out of control."

Surveyor asked if at any point he had to manipulate the resident's face during suctioning that could have been construed as a slap, V3 stated, "No I never touched his face. (V3 became argumentative with surveyor and began lecturing surveyor of the location of the trachea). V3 stated, "If you knew where his trachea is then you'd know his trachea doesn't move so I didn't do anything to him like that." Surveyor asked V3 to go through the events again for clarity in case anything was missed, V3 stated, "The resident coughed two to three times. At no time did his cough hit me. Because of the struggle and I suctioned him real hard, and I was upset, not frustrated. I had to press his hands down so I could suction him. I was moving his hand away and I did not stabilize his face. The trachea remains the same and I don't need to touch his face. I had to restrain his hands. There was another respiratory therapist on duty there but she was busy, so I did not get any help."

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During and after the interview, V3 affirmed and repeated his statements to the surveyor and to V4.

On 1/6/24 at 12:45 PM, R1 was observed seated in a chair in an upright position and was asked how he was doing, R1 stated that he was still upset about the situation that happened to him on Christmas and that V3 was still around after that occurred. R1 became upset and stated that no one did anything to V3 after he was slapped by him and indicated that he felt the facility chose not to believe him when he reported it to the nurse of what happened. R1 stated, "I told my sister, and she told me she would take care of it."

On 1/6/24 at 1:15 PM, R1's sister V15 requested to meet with surveyor. V15 stated, "I was informed by the facility you were here. I just got back from the police station. I've been telling the administrator (V1) that I did not want V3 to ever come in to take care of my brother, but she kept giving me excuses as if they didn't believe my brother. V1 told me that in case of an emergency that V3 needed to go into my brother's room, but he would take someone with him. I was like, why couldn't anyone else do that in an emergency, the guy slapped my brother! I told her (V1) why can't you just call 911?"

On 1/6/24 at 2:30 PM, V4 (VP of Clinical Operations) stated, "I told the administrator and director of nursing to take V3 off the schedule and we walked him out. Our plan is to terminate V3 and train our staff. I thought that there's a language barrier with V3, but he speaks good English. The administrator should've brought him in to conduct an in-person for interview. We're changing that process moving forward. At 3:00

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S9999	Continued From page 6 PM, V4 returned to surveyor and stated, "We terminated him. I'm going to refer the administrator (V1) and DON (V2) for training on how to conduct a thorough investigation including calling the police for any physical abuse, investigate alleged perpetrators in person, and in service when a resident indicates that they do not want to be taken care of by particular staff. We have to consider that to prevent psychosocial effect on a resident. I will have the Assistant DON (V12) conduct the in services for the whole staff on behavioral management." On 1/6/24 at 1:55 PM, V9 (Social Service Director) stated, "I met with the resident last night and checked on him on his well-being and how he was doing. I checked to see if he felt safe and felt comfortable in the building and he said he did. He mouthed words and it was very brief, and he didn't want to elaborate too much and said he was ok. He seemed calm and seemed comfortable and didn't see any distress that I saw. I was prompted to see him due to the investigation. The administrator told me to do this." Surveyor asked if it was her role to conduct a psychosocial assessment during these types of incidents and V9 affirmed that it was. Surveyor asked why no such assessment was conducted during the first alleged incident that was reported by R1 on 12/25/23, V9 stated, "I was on vacation the whole week, so I was not aware of it. I have an assistant V13 but from my knowledge no one directed him to be seen after the initial allegation." Surveyor asked what type of abuse training she received, V9 stated, "As directed by the administrator our procedure is to follow up after any alleged abuse. I was not informed of the one that happened on Christmas day. " On 1/9/24 at 2:10 PM, V14 (Medical Director)	S9999		

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stated, "I've been discussing this incident the last few days and am very aware of what happened. I was told by administration about this RT (respiratory therapist-V4) and about his history. That is a pattern. I did discuss with facility with the abuse situation on our aspect that has to be answered. Sometimes this therapist or any staff they are not children and should know how to respond to abuse. They all know abuse and should know how respond. When the new company took over the operations, they let this facility go down and didn't pay any attention. After this new operation, I took medical directorship about a month ago, so I have been working with management including abuse prevention. protecting residents is what I am working with the facility, and I am working closely with the facility. I have scheduled a meeting next Thursday. Abuse will be included in the QAPI meeting."

On 1/11/24 at 11:15 AM, V14 Medical Director met with surveyor and stated, "I am working closely with administration to improve their function. This incident should not have happened and even though the resident and the respiratory therapist stories don't match we still know that some abuse occurred. Surveyor asked whether administration acted effectively and efficiently to maintain the safety and psychosocial well-being of the resident, V14 stated, "Well in hindsight not for this instance, that is why I am here as part of quality assurance meeting to discuss changes moving forward." Surveyor asked since the original incident occurred last year on 12/24/23, whether a doctor should have examined him by then, V14 stated, "I have not seen him, yet, but I am on my way to see R1 after this meeting."

Facility policy on abuse preventions dated 2/2017 reads in part, "The facility affirms the right of our

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S9999	Continued From page 8 residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so the facility 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 abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. " (A)	S9999		