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	IL6000343	A. BUILDING: _____ B. WING _____	C 03/14/2024

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S 000	Initial Comments Complaint Investigations: 2491487/IL170143 2491757/IL170487 Facility Reported Incident of 02/17/2024/IL170409	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4: 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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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 Regulations are not met as evidenced by:

Based on interviews and record review, the facility failed to protect the resident ' s right to be free from sexual abuse by staff. This failure applied to one of three (R3) residents reviewed for sexual abuse that resulted in R3 being sexually abused by a facility RN (Registered Nurse). The facility also failed to follow their policy and procedures for preventing residents from further potential abuse by staff, after an allegation of staff to resident sexual abuse was made. This failure applied to one of three (R3) residents reviewed for sexual abuse investigation procedures and has the potential to affect the 126 residents currently in the facility.

Findings include:

R3 is an 81-year-old female with diagnoses that include history of Hereditary Hemochromatosis, Femur Fracture, Primary Generalized Osteoporosis, and Essential Hypertension who was admitted to the facility 03/02/2024. R3's past medical history does not include cognitive or psychological disorders.

On 03/04/2024 at 11:45 AM observed R3 sitting in a chair in her room with a cast covering her entire left arm. R3 stated she fell on Saturday

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03/02/2024 at her home and damaged her elbow and that is why she was admitted to the facility. In response to surveyor asking R3 about an allegation of sexual abuse, R3 stated she wants to forget about it. R3 stated there have been so many people coming to see her about it. R3 stated a male nurse observed her walking around in her room, walked her over to her bed sat her down, and told her he didn't want her walking around the room on her own. R3 stated he offered to help her undress because he saw she was in no condition to do it on her own with her arm being the way it was. R3 stated the male nurse left the room and returned. R3 stated the male nurse examined her mouth with his fingers and asked her if her teeth were hers and she answered yes. R3 stated the male nurse then began pulling her teeth as if to see if they were false and she assured him they were hers. R3 stated the male nurse then kneeled in front of her and placed his fingers in her pants and then inside her vagina and moved his finger around in a circular motion. R3 stated she stopped him there and didn't know what to make of what the male nurse had done to her. R3 stated the male nurse then told her I'm going to leave you now you're clean. R3 stated she asked the male nurse what that meant, and he stated it meant there was nothing in her that would cause her problems. R3 stated what the male nurse did made her feel dirty, angry, and violated. R3 stated she didn't realize what the male nurse was doing until it was over, and she then wondered if he would attack her next. R3 stated she then told another nurse, and the nurse called the police. R3 stated the male nurse was African or African American. R3 stated as a Christian what the male nurse did to her made her feel bad. R3 to appeared stressed, agitated, and sad while reporting the abuse allegation to the surveyor.

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On 03/05/2024 at 12:38 PM observed R3's facial expression change from relaxed and content to display a frown and discomfort when surveyor asked follow up questions about her sexual abuse allegation. R3 stated on 03/02/2024 V14 (Registered Nurse) told her he had to do what he was doing to her during the alleged sexual abuse incident, because it was his job and if he didn't do it, he would lose his job. R3 stated V14 had been in her room more than once that day telling her not to walk on her own which she didn't like. R3 stated during the incident V14 sat her on the bed, kneeled in front of her, and placed his hands in her pants. R3 stated she told the administrator she never wanted to see V14 again after the incident. R3 stated the administrator has since come back and talked to her about the incident and explained the process of admissions examinations and she told him she was not aware of that process because she had never been in a nursing home before. R3 stated she told the administrator what V14 did to her, and he didn't say much about it in response.

Initial Abuse Investigation Reports dated 03/02/2024 documents: Administration received report at 7PM from the nurse on duty that R3 reported to her family member an allegation of inappropriate touching during her assessment by her admitting nurse. R3 stated a male nurse, V14 (Registered Nurse), touched her on or near her buttocks and genitalia during her initial body check assessment. The alleged nurse and reporting nurse stated the resident appeared confused about the events of the allegation during initial interview. The reporting nurse informed that the resident told her he touched her inappropriately, the alleged nurse and a female nurse aide completed the initial assessment as

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part of their routine care during an admission with the patient's consent, the alleged nurse denied the incident, his assisting nurse aide stated there was no inappropriate behavior on part of the nurse as well. The administrator spoke with V12 (Family Member) responsible party who received the report, to inquire about conversation with the resident. V12 stated R3 felt the nurse touched her inappropriately during the process. Administration informed them there would be an investigation immediately initiated, the staff member would be suspended, and local law enforcement would be notified for report.

V14's (Registered Nurse) witness statement dated 03/02/2024 documents he explained to R3 that a head-to-toe assessment would be performed and obtained verbal consent from R3 to perform; attempt to perform complete assessment on R3 with a CNA (Certified Nursing Assistant) present for the entire assessment.

V15's (Certified Nursing Assistant) witness statement dated 03/02/2024 documents she was the CNA assigned to R3, she went in R3's room to do a skin assessment with the nurse, R3 was told everything that was going to be done with her consent prior to initiating; she helped the nurse assess R3's skin from head to toe, helped dress R3 when done and the nurse left the room after. V15 stated the nurse never returned to R3's room, the nurse was only assigned to do the admission and she was there with the nurse for the entire assessment.

Police Report dated 03/02/2024 documents at 7:04 PM police responded to the nursing home in regarding a criminal sexual assault report; R3 reported a male nurse penetrated her vagina with his finger. R3 could not confirm the time of the

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incident. R3 reported the nurse entered her room during the time she was using the bathroom. When she came out of the bathroom, she was unable to pull her pants up because of her broken arm, the male nurse assisted her to sit down on her bed. The male nurse then began asking questions about her teeth. After checking her teeth (possibly for dentures), the male nurse placed his hand in her pants and penetrated her vagina with his finger; R3 stated the male nurse moved his finger in a circular motion inside her vagina, she attempted to push the nurse away but couldn't then he left the room. R3 reported no one else was present during this incident. R3 described the nurse as darker skinned and speaking with an accent. The alleged perpetrator was identified as V14 (Registered Nurse) reported he went into R3's room with V15 (Certified Nursing Assistant) present to perform a full physical examination, both denied that V14 touched R3's vagina. V14 denied going into R3's room other than during the physical examination.

V13 (Charge Nurse) was interviewed and confirmed an initial physical examination procedure does not involve examining the genital area; and that she observed V14 go into R3's room multiple times after the physical examination. She (V13) does not know why V14 was in R3's room; no one else was in the room with V14. V13 stated that V14 is no longer R3's nurse, and he will not be going into the room anymore. V13 told the police officer she has taken over as R3's nurse for the night. V13 was given the report number for her records. The officer went back to speak with R3 one more time. The officer explained to R3 that V14 is no longer her nurse and should not be in her room.

R3's progress note dated 3/3/2024 6:04 PM

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documents a telehealth evaluation was conducted in response to an Allegation of Abuse. Patient reporting during admit that the male nurse inserted fingers into her vagina during exam.

V14's (Registered Nurse) personnel file was reviewed 03/04/2024 and documents a hire date of 03/18/2019. A Healthcare Worker Criminal History Records Information Check was performed 02/27/2019. A Consumer Reporting Agency Background Application was performed 02/27/2019. An Illinois State Police background check was performed 03/13/2019. A Global Human Resources Research report was performed 02/28/2019. A National Sex Offender Search was performed 03/13/2019. An Illinois State Sex Offender search was performed 03/13/2019. An Illinois Department of Corrections check was performed 03/13/2019. An Abuse training was completed in 2019 and does not include any other background checks or abuse prevention trainings after these time frames.

Statement from V2 (Director of Nursing) documents she interviewed R3 on 03/05/2024 in her room regarding the incident that occurred on Saturday 03/02/2024. R3 reported the (alleged) nurse escorted her into the building from the ambulance and sat her on the bed. R3 reported the (alleged) nurse asked her if she had dentures and asked her to open her mouth and proceeded to examine her mouth. R3 reported she didn't understand the need for his exam because she stated to him all her teeth were her own. R3 reported she was sitting at the side of the bed when the (alleged) nurse inserted his fingers in her vagina and scratched her and she knew it was wrong and asked him to stop because she is a virgin, and a man has never touched her down there. R3 stated the (alleged) nurse removed his

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hand and told her she was all clean and walked out of the room and never returned. V2 asked if the same man entered R3's room at all again with another worker, she stated no he never returned.

Statement from V13 (Licensed Practical Nurse) dated 03/06/2024 10:19 AM documents On Saturday 03/03/2024, V13 received a call from V12 (Family Member) of R3. V12 informed V13 that R3 was sexually assaulted by a male, and this male worked at our facility. V12 then asked was this a normal thing that happens at the facility. V12 further stated that R3 has never been touched down there before. V12 was very upset, she demanded a call back from the administrator of the facility. V13 tried reassuring V12 there may have been a misconception or misunderstanding and explained the admissions process and requirement of having a physical assessment. V12 stated she understood this, but the nurse touched R3 inappropriately. V12 stated R3 told her that the male employee put his finger in her. V13 told V12 she would call the administrator and will give her a call. V13 reported to the administrator that V12 told her R3 informed her she was touched inappropriately and does not recall telling him that V12 stated the male put his finger in R3's vagina, however she did inform the doctor of this. V13 stated she was instructed to call the police and notify the physician.

Statement from V10 (Assistant Director of Nursing) dated 03/06/2024 documents when R3 was asked about what occurred this weekend she (R3) stated "when is this going to be over." V10 explained that it is not our intent to make her revisit this but just part of a thorough investigation and that clinical staff are mandated reporters and required to take the steps both the facility and the state are performing. R3 started to state that she

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shouldn't have said anything, and V10 reassured her that our goal is to make sure she feels safe and cared for. R3 then began describing how the nurse in question walked her in from the ambulance but it was a long way, he took her to the room, and she sat down on the edge of the bed, she then changed focus to the fall that resulted in her arm being fractured.

Final Abuse Investigation report dated 03/08/2024 documents: The police were called at 7:04 PM and reported to the facility for investigation. Administration instructed V13 (Registered Nurse) to have V14 stop work and come off the unit away from resident contact to await police interview and sit with him until then. Per police records the officer arrived on scene at 7:24 PM, the officer interviewed the employees involved including V13, V14, and V15 (Certified Nursing Assistant) as well as R3. Per police record R3 reported that a male nurse had penetrated her vagina with his finger and stated this occurred sometime this afternoon but was unsure of the exact time. Upon interview V13 and V14 reported giving R3 a head-to-toe visual examination and both denied any touching of the vaginal area. V14 denied going into R3's room other than just for the assessment. The police interviewed V13, and she (V13) reported observing V14 go into R3's room multiple times after the initial exam and did not know the reason. V13 stated no one else went in the room with V14. V14 and V13 were in the nurse's station during the duration of the investigation while he was speaking with the officer and closing out his records to turn over his patients to his coworker V13. At 8:11PM, the administrator called the facility to check on the progress and asked V14 to stop his work and leave the premises since the police completed their interview with him. The police finished their

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interviews with all involved and left the facility at 8:42 PM.

On Monday Morning 03/04/2024 the state survey agency came into the facility to conduct a facility reported incident review. V1 (Administrator), and V2 (Director of Nursing) interviewed R3, and they were informed of additional information including the allegation that V14 inserted his fingers into her vagina during an examination. R3 described the oral examination and body check and did not recall the witnessing nurse aide being part of the examination. R3 reported V14 did not return later, and this was the only incident. R3 reported she could not recall the time of the incident. On further follow up interviews with V14 during the course of the investigation, V14 reported he initially received the resident's admission paperwork from the ambulance company when she(R3) was admitted to the facility around 3PM. Shortly after R3's arrival V14 saw R3 down the hallway walking near the therapy gym and offered to assist her back to her room. While walking R3 to her room V14 reported he met V15 (CNA) at R3's doorway and she took over to assist her to her bed. Later in the shift between 4PM-5PM, V14 approached V15 and requested assistance with conducting a body assessment for R3. The allegation could not be substantiated; R3's assessment identified cognitive impairment and she could not remember the witnessing nurse aide as assisting the nurse during the body assessment. V14 was supervised by staff and in the presence of law enforcement and no contact with residents after the allegation was made. The initial confusion of the incident was contributed to cognitive impairment during her initial body assessment. The cognitive impairment of the resident is supported by the evaluation of social service, licensed speech therapist and

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documents from her most recent hospitalization.

R3's Admission Clinical Hospital Reports dated 02/27/2024 documents she is an 81-year-old female with a past medical history of Hereditary Hemochromatosis, Hypertension, Osteoarthritis who was seen at the hospital for left elbow pain and reported that while she was at home with two of her family members she slipped and fell while outside doing yard work and trying to start the lawnmower. A Left elbow x-ray revealed a fracture of her left arm; she is neurovascularly intact, alert, and oriented x/times 3 (to person, place, and time), with normal speech.

Physical Exam Neurological Status: Normal orientation, normal memory; the hospital Physician's Progress Note dated 02/28/2024 documents intervention options and potential risks and benefits of interventions for R3's fracture were discussed with her and her family members; R3 is an elderly individual with frail body habitus. She (R3) is a right-hand dominant individual who lives alone and is an active person. she also drives a car. She (R3) chose the surgical intervention to get the best possible outcome from this fracture. She understood the risks and benefits and understood that surgical complications can occur and may require additional interventions. R3 and her family members had many questions which were addressed, and it was believed they understood. R3 has signed the consent for the surgery. R3's hospital/clinical report which includes a CT scan (computerized tomography) of her head do not include a reference or note of cognitive impairment.

R3's Admission Evaluation dated 03/02/2024 at 5:28 PM created by V14 (Registered Nurse)

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documents her mentation as alert and oriented x3. R3's neurological status as oriented to person, place, and time; has the ability to move her upper and lower extremities. R3 has no impairment in lower extremity range of motion, with steady sitting, standing, and gait balance.

R3's admission progress note dated 3/2/2024 at 6:01 PM created by V14 (Registered Nurse) documents she is an 81-year-old female patient received from local hospital this afternoon accompanied by local transportation company. Admitting for post care after fall at home, resulting in an elbow fracture. Skin assessment completed, bruises noted on left knee area, right arm, and left breast side. Left mid back area bruises/redness noted. Redness noted on buttock area. Left arm cast noted (left elbow fracture). Safety maintained, call light and personal belongings in reach, bed in lowest position, all needs attended by staff. Report given to on floor nurse.

R3's Current Physician Orders do not include cognitive or psychotropic medications.

R3's admission social services comprehensive assessment section for trauma factors including abuse dated 03/03/2024 at 1:36 PM documents she has a history of abuse with no factors that increase the resident's vulnerability such as dementia, confusion, disorientation, poor insight/poor judgment, or poor communication skills and no psychiatric history and/or present mental health diagnosis, including psychotic symptoms (e.g., delusional thinking, hallucinations), or possible misinterpretation of events and the intentions of others. The community survival skills section documents R3 is sufficiently alert, oriented, coherent, and

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knowledgeable allowing her to be considered for independent outside pass privileges. R3 knows how to ask for/seek help in an emergent or problematic situation and appears to be capable of unsupervised outside pass privileges at this time. The section for Prior Living Arrangements/Discharge Potential documents, R3 previously lived at home alone independently, reported having 7 stairs to enter her home, 17 stairs inside her home leading down to the basement and approximately 15 upstairs, and has good discharge potential.

R3's Minimum Data Set dated 03/05/2024 documents she has a Basic Interview for Mental Assessment score of 12 out of 15.

R3's progress note dated 3/4/2024 14:02 created by V17 (Social Services Worker) documents social worker met with patient. Patient is a pleasant 81-year-old female admitted to the facility on 3/2/24. Patient reports living alone in a bungalow style home with about 7 stairs into house and about 14 stairs into basement and to the second floor. Patient provided her primary care physician's name and phone number. It is the patients wish to go back to her home upon discharge.

R3's Medical Practitioner Note Progress Note dated 3/8/2024 at 12:00 PM documents her neurological status as Grossly normal without focal neurological deficits.

On 03/04/2024 at 1:25 PM V1 (Administrator) stated he did not send R3 to the hospital because he was originally told R3's alleged sexual abuse incident involved her being touched inappropriately on a surface level. V1 stated however after further conversation now it seems

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the nurse allegedly went further and touched her inwardly. V1 stated R3 wasn't aware there was CNA (Certified Nursing Assistant) with the nurse the entire time he was with her so there seems to be some confusion.

On 03/04/2024 at 1:39 PM V12 (Family Member) stated on 03/02/2024 R3 told her that she was told a physical or body check needed to be performed and she didn't expect they had to touch her on her bottom and didn't expect a finger to go into her vaginal area. V12 stated after she received this report from R3, she called the facility and asked to speak with a female nurse to ensure she didn't get the male nurse who was alleged to have touched R3 inappropriately. V12 stated she spoke with V13 (Licensed Practical Nurse) and informed her of what R3 told her and V13 was appalled. V12 stated she asked V13 if sticking a finger in the vagina was a normal procedure and V13 stated it was absolutely not and was shocked of what was reported. V12 stated V13 advised she would inform the Administrator about what was reported. V12 stated V1 (Administrator) then contacted her. V12 stated V1 was concerned that R3 may be confused but she is a sharp lady and is never confused. V12 stated R3 even told her she is a single woman and has never been touched like that in her life. V12 stated V19 (Police Officer) from local police department contacted her as well. V12 stated on the day of the incident after V13 spoke with R3 she told her she needed to call the police. V12 stated the police came and spoke to R3 at the facility and then contacted her. V12 stated R3 doesn't have any children and was never married. V12 stated R3 didn't feel comfortable with a male nurse telling her how to go to the bathroom. V12 stated R3 did not mention anyone else being in the room during the

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incident, but the facility mentioned someone else was in the room which they should have been. V12 stated she is pretty sure she told V1 everything that R3 told her.

On 03/04/2024 at 2:37 PM V13 (Licensed Practical Nurse) stated V12 (Family Member) reported to her Saturday 03/02/2024 that R3 informed her that a male placed his fingers inside her vagina. V13 stated she tried to explain the process of assessment to V12. V13 stated she was R3's nurse but V14 (Registered Nurse) performed the admission physical assessment and all procedures involved in admitting a resident to the facility. V13 stated she initially notified the administrator of what was reported to her and then the police. V13 stated she spoke to the police officer after he interviewed the alleged nurse and asked what she thought about the whole situation. V13 stated she responded that she wasn't sure what she thought about it because she wasn't familiar with the resident or employee.

On 03/04/2024 at 4:33 PM V15 (Certified Nursing Assistant) stated while working the evening shift from 2-10PM on 03/02/2024, R3 was newly admitted and while getting R3 situated in her room V14 (Registered Nurse) asked her to assist him with completing R3's physical skin assessment. V15 stated R3 was wearing pants and a shirt that she was admitted in. V15 stated V14 asked R3 if it was ok to perform the skin assessment. V15 stated during the assessment she and V14 raised R3's shirt just above her breast and pulled her pants halfway down to observe for any abnormalities. V15 stated afterwards they also turned her on her side to check her back and bottom. V15 stated the whole process was explained to R3 as it was taking

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place. V15 stated V14 also continued speaking with R3 about her medications. V15 stated she doesn't recall V14 going back into R3's room after the assessment and he left the room when she did. V15 stated she later went back into R3's room when she pulled the call light and assisted R3 with removing tags from her clothes. V15 stated at approximately 5:30 PM R3 was up and around in the hallway. V15 stated she was assigned to 11 rooms on the unit where R3's room was located during her shift. V15 stated she also brought R3 her dinner around 6PM. V15 stated she last saw R3 when she collected her tray during which time, she was lying in her bed sometime at or after 7 or 8PM. V15 stated she did not have her eyes on V14 throughout her entire shift and could not be certain of his whereabouts at all times.

On 03/05/2024 at 2:37 PM V2 (Director of Nursing) stated V14 (Registered Nurse) wasn't assigned to R3's room on 03/02/2024, however when there are multiple admissions the nurses' alternate admissions. V2 stated V14 normally works on the unit where R3's room is located.

On 03/05/2024 at 3:14 PM V14 (Registered Nurse) stated that on 03/02/2024 he was working on another unit but there were multiple admissions on the unit where R3's room was located, and he was assigned to do admissions only on that unit. V14 stated he and a CNA (Certified Nursing Assistant) went to R3's room together to perform an assessment. V14 stated upon entering R3's room she was sitting on her bed and he and the CNA explained the assessment procedures and she consented to the procedures. V14 stated throughout the whole assessment the CNA was present. V14 stated after he left once the assessment was complete

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and the CNA continued to assist R3, and he never returned to the room again. V14 stated while he was working, he saw R3 walking in the hall on the other side of the unit where R3's room is located near a different room and told the CNA R3 was out of the room and asked them to redirect R3 back to her room. V14 stated when we explained to R3 about the head-to-toe assessment she (R3) seemed alert and oriented but after that we found her alertness to be on and off because after explaining safety protocols such as not trying to ambulate on her own or using the call light to call for assistance when she needed it, she continued to leave her room and was not using the call light. V14 stated R3 can walk by herself, but her gait was unstable. V14 stated after R3 was assessed by therapy to determine if she can ambulate with a walker or wheelchair etc. it would be safer for her to ambulate. V14 stated after speaking with the police he was taking care of his patients in the 17 rooms he was assigned until the administrator told him to clock out and go at approximately 8:15 to 8:30 PM. V14 stated his CNA was assisting him with working with the residents he was assigned to. V14 stated once he completed R3's admission assessment he provided the report to V13. V14 stated after the police officer's arrival he still needed to pass medications and perform other duties and was not aware of what was going on with the situation, so he continued working until he left the facility. V14 stated the police spoke with him and the CNA around 7 or so but before he left at 8:30 PM.

On 03/05/2024 at 3:37 PM V16 (Certified Nursing Assistant) stated she has worked for the facility for approximately 4 weeks and has worked with R3 once on Sunday 03/05/2024 and has been assigned to her today. V16 stated R3 seems to be alert and does not appear confused at any

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time.

On 03/05/2024 at 3:51 PM V17 (Social Worker) stated R3 lives alone in a bungalow style home and has been doing things all alone. When asked by surveyor about R3's discharge potential V17 stated R3 can likely go home with some home health services and home maker services. V17 stated R3 seems cognitively intact and was able to give me the last four digits of her zip code, was able to show her where all her contacts were written down in her room, and stated R3 expressed that she writes everything down to keep up with it. V17 stated R3 doesn't always want to press the call light for assistance but seems alert and oriented and has a BIMS (Basic Interview for Mental Status) score of 12.

On 03/05/2024 at 4:14 PM V18 (Human Resource Director) stated she runs license checks yearly along with another database to check for any background or disciplinary issues regarding the nurse's license. V18 stated the database will also show you if a license was removed and reinstated as well as any licenses under your name. V18 stated she is not sure why these checks have not been conducted for V14 (Registered Nurse) since he was hired. V18 stated there have been a few transitions in the company, administration, and HR (Human Resources) personnel of the facility in the last two years. V18 stated she was trained to perform these checks while working at a previous facility. V18 stated she has not received any formal training on running employee background checks since she began working at this facility in July. V18 stated V1 (Administrator) asked her about what the background check policy is for this facility, and she text corporate to confirm if the practices she had been trained on at the previous

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facility were the same for this facility. V18 stated V20 (Corporate) advised her that licensing status and license related background checks should be ran yearly to ensure they are renewed and in good standing. V18 stated who knows what these people have done if we have only run their license checks every 2 years. V18 stated she is not sure why V14's background has not been run since he was hired but she has been cleaning up the workload from the previous HR staff and she is behind in running these checks on staff. V18 stated she will prioritize doing this based on becoming aware of V14's background check status being overdue.

On 03/06/2024 at 3:11 PM V1 (Administrator) stated he asked V14 (Registered Nurse) to stay with the nurse who reported the abuse allegation until the police arrived and began interviewing them and he left after. V1 stated V14 was supposed to punch out after he was interviewed by the police. V1 stated he would have to look at the time record to confirm when V14 left the and is going through the process of confirming when V14 left.

On 03/06/2024 at 3:35 PM V1 (Administrator) stated he wasn't in the building the day of the alleged sexual abuse incident with R3. V1 stated there were inconsistencies in what R3 reported regarding the sexual abuse allegation. V1 stated the inconsistencies in what R3 has reported to him when interviewing her with V2 (Director of Nursing) included stating there was only one instance when she saw V14 (Registered Nurse), V14 came into her room when she was attempting to use the bathroom. V14 came in and told her to stay in the chair or bed and he would assist her. That V14 came in and gave her an oral assessment, checked her teeth, did a body

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check on her then checked down in her genitalia and inserted his finger into R3's vagina, at which point she was stunned. He (V14) finished up and he left the room. V1 stated he interviewed V15 (CNA) to go over the situation and she stated the only other time she saw V14 with R3 was when R3 left her room either before or after the assessment, likely before. V1 stated V15 reported that R3 was down by therapy and likely lost, and V14 was going past at the time and V15 saw V14 redirect R3 back to her room, then she went in to assist him with the initial nursing assessment and helped R3 get set up for the assessment. V1 stated R3 doesn't remember that the CNA was there during her nursing assessment and reports V14 engaged in the extra activities with her by himself. V1 stated R3 also maintains she was only with V14 one time and it's confusing as to if this was during the initial assessment or any other time and the fact that she's reporting only seeing him the one time. V1 stated there is no way for him to know if R3's recollection of the moments involved in the alleged sexual abuse incident that day could be affected due to trauma. V1 stated there is evidence out there that trauma does affect the memories of people who have experienced sexual abuse. V1 stated there have been objective assessments that indicate R3 has cognitive impairment, social services staff did a BIMS (Basic Interview for Mental Score) assessment that show cognitive impairments, and there are also cat scans (computerized tomography) from R3's hospital records that indicate brain impairment so there's a lot going on and it's difficult to say where her cognition really lies. V1 stated the fact that R3 is also confusing her timeline of events also presents some issues. V1 stated R3 maintains only having one encounter with V14 and reports inconsistencies in the timeline of the events that took place. V1

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stated it wasn't until Monday R3 reported to him that V14 placed his fingers inside her vagina. V1 stated the initial report from V13 (Licensed Practical Nurse) was that R3 was touched inappropriately and then later after having some more thought about it she added the additional detail of vaginal penetration.

On 03/06/2024 at 3:58 PM V22 (Detective) stated he was just at the facility to go over the facts of the case with R3 and to do an additional interview of her recollection of the events. V22 stated It was initially reported R3 was coming out of the bathroom and having a difficult time pulling her pants up due to the condition of her arm. The nurse came in to assists her with pulling her pants up then digitally penetrated her and used his finger in a circular motion. V22 agreed that time, trauma of the event, and constant questioning may have an impact on R3's recollection of the events. V22 stated also due to R3 falling at the house, having surgery, and being transported to the facility for rehab. She (R3) may be unable to recollect the events in a clear manner. V22 stated he's no expert in recognizing a person's cognitive impairments however R3 spoke clearly and didn't seem to have any cognitive issues. V22 stated just as the surveyor inquired, R3 is getting tired of telling the story over and over.

On 03/07/2024 at 12:40 PM V12 (Family Member) stated she called to check in on R3 at approximately 6:52 PM on Saturday 03/02/2024 and that is when R3 informed her about sexual abuse that took place after arriving to the facility. V12 stated she called the facility right after she got off the phone with R3. V12 stated she isn't sure what time R3 arrived at the facility. V12 stated she feels the hospital advised R3 would be

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leaving from the hospital in the afternoon, so it makes sense that the documentation reported she arrived in the afternoon. V12 stated she called the facility right after she got off the phone with R3. V12 stated R3 reported the sexual abuse was done to her by a male nurse that was assigned to her room to do an assessment on her. V12 stated R3 reported she was basically told by the nurse that his actions were part of the assessment procedures. V12 stated the whole concept that she was getting from what R3 was reporting was the sexual abuse was done by whoever was assigned to admit her and perform the physical assessment. V12 stated she asked R3 was she informed by the nurse what was going to be done to her before it happened, and she stated no it was just done. V12 stated R3 even told me afterwards that the nurse stated he had to do it, or he would lose his job. V12 stated R3 told her what happened to her within an hour or two of the event.

On 03/07/2024 at 1:11 PM V2 (Director of Nursing) stated on 03/02/2024 after the police finished speaking with V14 he completed wrapping up, gave his report to the nurse, completed the narcotic count, and gave the nurse the keys to his medication cart. V2 stated V14 was with V13 (Licensed Practical Nurse) the entire time at the nurse's station during this time and he didn't do anything more. V2 stated V14 was removed from the patient care area during this time. V1 (Administrator) stated he can't say if it would take V14 over an hour after speaking to the police to wrap up duties and leave the building. V1 stated he spoke with V14 when calling back to the facility that night to follow up on what was going on and told V14 to close everything out and leave.

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On 03/07/2024 at 2:35 PM V2 (Director of Nursing) stated there were only two nurses on the unit where R3's room is located and no supervisor on 03/02/2024. V2 stated during the time V13 (Licensed Practical Nurse) was supervising V14, V13 was at the med cart and V14 was behind the desk at the computer closing out the report, then he gave V13 the narcotic count and keys and left. V2 stated no other nurses replaced V14 during that shift.

On 03/11/2024 at 1:47 PM V28 (Speech Therapist) stated R3 was evaluated on 03/04/2024 to show significant cognitive deficits based mostly on her short-term memory, daily problem-solving skills, and thought organization. V28 stated when he saw R3 again on 03/06/2024 for therapy he observed a 100% improvement in her problem-solving ability. V28 stated the evaluations are not 100% accurate because they may not accurately reflect an individual's memory capability. V28 stated in an evaluation memory is assessed using word recall and individuals may not recall words as accurately as day-to-day events such as what they ate for breakfast or what they did that day. V28 stated during his time with R3 on 03/06/2024 she was very alert, and he educated her on memory strategies which included writing things down. V28 stated R3 reported she likes writing things down and does it often and she (R3) has a calendar. V28 stated R3 also performed pretty well that day on problem solving and judgment tasks. V28 stated R3's overall cognition status on 03/06/2024 was alert and oriented times four (to person, place, time, and situation).

The abuse prevention trainings/in-services from 2023 the facility provided have no documentation that V14 (Registered Nurse) participated in or

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received the training.

The facility's daily schedule for 03/02/2024 documents V14 (Registered Nurse) was scheduled to work from 2:30 PM - 10:30 PM on the unit where R3's room was located and was assigned to 15 rooms on the unit.

V14's (Registered Nurse) time record dated 03/02/2024 documents he clocked in for his shift at 2:30 PM and out for his shift at 8:30 PM.

March 2024 Medication Administration Records for R12, R13, R14, R15, R16, R17, R18, R19, R20, and R21 document V14 (Registered Nurse) administered medications on 03/02/2024 after it was reported to the administrator at 7PM that he sexually abused R3 up until he left the facility at 8:30 PM. R22's March 2024 Medication Administration Record documents V13 (Licensed Practical Nurse) administered medication on 03/02/2024 after she received report of R3's sexual abuse allegation against V14 and had administered medication during the time V14 remained in the facility until he clocked out from his shift at 8:30PM.

The facility's Medication Administration Policy reviewed/received 03/12/2024 states: "Document as each medication is prepared on the Medication Administration Record."

The facility's Abuse Policy received/reviewed 03/02/2024 states: "The facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse. 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

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occurrences of abuse."
"This will be done by: Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; immediately protecting residents involved in identified reports of possible abuse."
"The facility will take steps to prevent potential abuse while the investigation is underway."
"Employees of this facility who have been accused of abuse will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse is unsubstantiated."

Per the Department of Justice Canada at https://www.justice.gc.ca/eng/rp-pr/jr/trauma/p4.html "Cognitive models highlight the nature of the traumatic memory: fragmented, associated with intense arousal, readily primed and triggered, and poorly contextualized into memory. As a result, memories of traumatic events such as a sexual assault can be fragmentary. It can be difficult for victims to recall many details of a sexual assault in a complete or linear way."

(A)
Statement of Licensure Violations 2 of 4:
300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)6)

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

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	IL6000343	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF OAK LAWN	6300 WEST 95TH STREET OAK LAWN, IL 60453

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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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide effective and individualized fall interventions for a resident assessed to be at high-risk of falling. This failure affected one (R6) of one resident reviewed for falls which resulted in R6 requiring urgent hospitalization for pain, and subsequently being diagnosed with a fracture of the right hip.

Findings include:

R6 is 76 years old and admitted to the facility 1/5/24 with diagnoses that included Dysphagia, Cognitive Communication Deficit, Malnutrition, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Osteoporosis. R6 is assessed to be alert to person and situation, but has episodes of confusion, according to assessments in the electronic health record.

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R6 has had seven falls in the facility since admission (approximately five weeks) with the most recent fall on 2/16/24 resulting in a fracture of the right hip. Four of the seven falls were documented to have occurred while R6 was sitting in the wheelchair and while not being monitored by staff or in a highly visible area.

Fall incident report dated 2/16/24 indicates that nursing staff had recently attended to R6, assisted R6 to the washroom and left R6 in the wheelchair inside the bedroom. Shortly after while nursing staff was rounding, R6 was found lying on the floor and R6 said R6 was trying to get to the restroom. (R6) was assessed to have hip pain and was placed in bed using a mechanical lift. The nurse on duty gave acetaminophen for the complaint of pain and called the provider to order portable x-ray.

According to nursing progress note written following the shift on 2/17/24 at 1:40PM when the x-ray technicians reported to the facility, R6 demonstrated too much pain to carry out the procedure. R6 was then sent to the emergency room via 911. R6 was admitted to the hospital with diagnosis of Right Hip Fracture.

According to hospital records dated 2/17/24, R6 underwent surgical intervention to treat the fracture and returned to the facility on 2/21/24.

On 3/5/24 at 1:05PM V23 COTA (Certified Occupational Therapy Assistant) said that they had been working with R6 since admission. V23 said that since the fall with fracture, R6 is less motivated to complete the exercises, likely because of pain and anxiety. V23 stated typically the nurse is asked to medicate prior to therapy

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sessions which occur at least five days during the week.

Care Plan for falls was initiated 1/5/24 on admission and shows revisions after each fall, however, does not address prevention of falls occurring from the wheelchair.
It is to be noted that after the fall on 2/16/24, the care plan shows the following added interventions: "Provide nonslip wheelchair cover" (Date Initiated: 2/16/24) and "Evaluate multiple falls to determine commonalities or patterns" (Date Initiated: 2/22/24).

On 3/7/24 at 3:00PM V29 Restorative Nurse said, that R6's fall interventions were being managed as a joint effort from the nursing and restorative teams. V29 said, that they were not sure of all the interventions placed for R6 to prevent falls and referred surveyor to the electronic health record.

On 3/11/24 at 12:10PM V31 Registered Nurse said, V31 was the nurse on duty when R6 fell on 2/16/24. V31 said an intervention placed for falls was to have R6's room closer to the nurse's station and an anti-slip pad was placed in the wheelchair seat, but R6 fell because R6 was standing up out of the wheelchair to walk and then fell. V31 acknowledged that R6 was alone while sitting in the chair unsupervised and the fall was unwitnessed.

Fall prevention and Management Policy revised 1/24 states in part; Guidelines: 2. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. Facility Guideline following a fall incident: 3. A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at "high

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risk" for falls; a score of less than 10 indicates "at risk" for fall. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.

(A)
Statement of Licensure Violations 3 of 4:
300.610a)
300.1210b)
300.1210d)6)

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 care needs of the resident.

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility sent a resident with impaired mobility, who requires maximal assistance to a medical appointment, without ensuring that the resident had adequate supervision prior to leaving the facility unsupervised. This failure applied to one of one (R7) resident reviewed for supervision.

Findings include:

R7 has multiple diagnoses including but not limited to the following: Orthopedic Aftercare, Muscle Disorder, Muscle Weakness, Cognitive Communication Deficit, need for assistance with personal care, Left Femur Fracture, Depression, Hyperlipidemia, ESRD (End Stage Renal Disease) with Dependence on Dialysis, Hemiplegia, and unspecified fall.

On 3/4/24 at 1:25PM, V4 (family member) was interviewed regarding R7 and appointment on 2/21/24. V4 said I was unable to attend the appointment with R7 on 2/21/24 and the facility knew I could not attend on the day before, 2/20/24. V6 (family member) was not made aware of the appointment till 2/19/24 and I was

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made aware by them on 2/20/24. I did not have much time to make accommodations and I work full time.

V4 said the facility told us that they did not have a staff member to go with him to the appointment. He was at another facility previously and they always had an escort go with him. It does not seem like they do that at this facility. However, it is my understanding that he did attend the appointment on 2/21/24 without an escort.

At 2:30PM, V3 (Unit Secretary/Transportation CNA) was interviewed regarding scheduling appointments and R7's appointment on 2/21/24. V3 said we do not typically send an escort with someone when they have appointments. I consider the family first however if the family cannot come to an appointment and we have enough CNA's scheduled, I will speak with the scheduler and see if a CNA can go with to the appointment. If we are not able to provide an escort or if family is unable to attend, I will reschedule the appointment. If a resident needs an escort, we would not want to send them out to an appointment without one.

V3 said this was my second time rescheduling R7's orthopedic appointment. The first time the family was unable to go with him. The second time, I found out the day before the appointment that the family was unable to go with R7 as well. However, it was my understanding that R7 did not need an escort for the appointment. The appointment was at a hospital, and they have transporters there. The family wanted him to attend this appointment. R7 was sent to the appointment on 2/21/24 without an escort. If I knew he needed an escort for this appointment, I would have rescheduled the appointment.

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On 3/5/24 at 11:50AM, V2 (Director of Nursing) was interviewed regarding appointments and providing escorts for residents. V2 said when a resident has an appointment, we encourage the family to attend alongside the resident. In the event the family cannot attend, and they are assessed whether they need an escort. If they are determined to not need an escort, they can go alone, however if the doctor's office is requesting an escort, we will try to send an escort. V2 said an escort is necessary when the resident has decreased mobility.

It is to be noted that per Minimum Data Set dated 1/3/24 shows R7 has impairment on both upper and lower extremities, and varies between need moderate assistance, maximum assistance, and dependent on staff.

Facility policy titled Appointments and Transportation with last review dated of 2/9/2023 states in part but not limited to the following: If the family will not be accompanying the resident, the unit clerk, HIM Director, or designee will inform the Director of Nursing to determine if an escort is needed for the resident.

(C)
Statement of Licensure Violations 4 of 4:
300.610a)
300.1210b)
300.1210d)1)
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

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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 care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain an available supply of pain medication as ordered for a resident. This failure applied to one of one (R6) resident reviewed for pain and resulted in R6 experiencing uncontrolled pain, rating 10 out of 10, related to a fracture of the right hip sustained

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while living in the facility.

Findings include:

R6 is 76 years old and admitted to the facility 1/5/24 with diagnoses that include Dysphagia, Cognitive Communication Deficit, Malnutrition, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, And Osteoporosis. R6 is assessed to be alert to person and situation, but has episodes of confusion, according to assessments in the electronic health record.

A Comprehensive Pain Assessment was competed at the time of admission dated 1/5/24 which indicated R6 did not have any acute or chronic pain. According to the electronic medical record, seven falls have been documented for R6 since admission, with the most recent fall occurring 2/16/24 that resulted in hospitalization and surgical interventions to treat a fracture of the right hip.

Hospital discharge medications ordered acetaminophen 325 milligrams (two tablets) and tramadol 50 milligrams every eight hours as needed for pain. Upon return to the facility, Physician's Order Sheet (POS) included two medications to be utilized for pain management- acetaminophen 325 milligrams (one tablet) every six hours for pain, and tramadol 50 milligrams every eight hours as needed for pain.

While on the unit on 3/11/24 at 12:36PM, R6 was observed awake lying in bed and preparing to eat lunch. A CNA (Certified Nursing Assistant) was assisting and setting up the lunch tray and repositioning. While repositioning, R6 was observed to have facial grimacing and furrowed brow. R6 pointed to the right and said, my hip and

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butt hurt really bad. It seems like it hurts all the time- the nurses and the doctors don't do enough for me when I have asked them, so I just sit and live with it.

At 12:43PM, V24 LPN (Licensed Practical Nurse) said, that R6 had not been given any medication or pain interventions at any time during the shift since 6:30AM. V24 went to assess R6 who stated a numerical pain scale of 10 out of 10. V24 returned to the medication cart and noted that the pain medication Tramadol was not available. V24 said that they remember giving the last tablet while working 3/8/24 but could not remember if it was reordered at that time. V24 said that the medications are usually ordered directly from the Medication Administration screen in the electronic chart and can be accessed when signing off on the medication. V24 acknowledged that the pain medication would not have been available after giving the last dose.

On 3/5/24 at 1:05PM V23 COTA (Certified Occupational Therapy Assistant) said that they had been working with R6 since admission. R13 said since the fall with fracture, R6 is less motivated to complete the exercises likely because of pain, and anxiety and typically the nurse is asked to medicate prior to therapy sessions which occur at least five days during the week.

The Medication Administration Record for February and March (to present date) shows nurse signatures for administering tramadol are absent, however, the medication was signed out on the controlled substance monitoring log for five tablets which was received by the facility on 2/21/24.

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Care Plan dated 2/22/24 lists nursing interventions that include, administer pain meds and treatments as ordered, assess effectiveness of pain medication, assess pain characteristic: duration, location, quality and monitor for nonverbal indicators of pain (moaning, crying, grimacing, wincing)

On 3/12/24 at 12:40PM V2 Director of Nursing said that the nature of nursing is that any medications given should be documented on the medication administration record, and with as needed medications, the pain assessment should be documented when the medications are given. The nurse should be assessing the resident at least once per shift and when asking for pain medications, I am not sure why the controlled sheet does not correlate with the administration record, or why the medication was not ordered at the time the last pill was removed. The pain medication should always be available to be give as ordered. V2 also said, according to the hospital transfer record, R6 should have been receiving two tablets of acetaminophen unless expressly stated differently by the physician. V2 was unaware of the discrepancy between the transfer order and the current physician order sheet.

Medication Administration Policy revised 1/24 states in part: Guideline- 24. Document reason and response for any PRN (as needed) mediation.

Facility Policy-Pain Management revised 1/24 states in part: Guidelines: The pain management program is based on a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it and exists whenever he or she says it does. "Pain

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Management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition ad established treatment goals. Pain management is a multidisciplinary care process that includes the following: Observing for the potential for pain; Effectively recognizing the presence of pain; Identifying the characteristics of pain; Addressing the underlying causes of the residents pain; Developing and implementing approaches to pain management; Identifying and using specific strategies for different levels and sources of pain; Monitoring for the effectiveness of intervention; and modifying approaches as necessary. It is important to recognize cognitive, cultural, familial, or gender specific influences on the resident' ability or willingness to verbalize pain. For example, some cultures value stoicism and a high threshold for pain which may influence a resident's wiliness to report pain or accept pain-relieving interventions.
Policy: 4. If nursing recognizes pain, the staff may attempt non-pharmacological intervention, physical modalities, body alignment, rehabilitation therapy, exercises, ad/ or cognitive/behavioral interventions. 5. Licensed Nursing may notify the Health Care Provider of any new development of pain, change in pain, change in condition that could potentially cause pain, for pharmacological interventions based on the individual's pain factors. 6. If pain has not been managed consistent with the resident's goals and needs, the interdisciplinary team may need to reconsider current interventions ad revise those interventions as needed; or if pain has been maintained and/or resolves, the nursing staff will work with the physician to taper or discontinue analgesics.

(B)

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