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	IL6006779	A. BUILDING: _____ B. WING _____	C 03/18/2024

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OAK LAWN RESPIRATORY & REHAB	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

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S 000	Initial Comments FRI of 3/2/2024/IL170485	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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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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 interviews and record reviews, the facility failed to protect a resident (R1) from physical abuse by staff and failed to follow their abuse protocols by staff not promptly reporting an incident of resident abuse. This failure applied to one (R1) of four residents reviewed for abuse and resulted in R1 being emergently transferred to the local emergency room for evaluation of pain to his head, neck and ribs and subsequently being admitted for assault and a fracture to his right third digit; this failure also led to a delay in the initiation of an abuse investigation as a result of staff not immediately reporting the abuse.

Findings include:

R1's referral documentation from previous facility dated 02/22/2024 reviewed, no behavior documentation noted.

R1's electronic medical record indicated that resident admitted to the facility on 02/27/2024. R1's nursing progress note dated 02/27/2024 23:26 (11:36 PM) indicated R1 admitted from another nursing home and is "alert and oriented times three." There was no Brief Interview for Mental Status (BIMS) Score available for R1.

R1's general progress note dated 03/02/2024 19:58 (07:58 PM) submitted by V3 (Registered

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Nurse) indicated that R1 came to the nurse's station that morning to heat up some food in the microwave. V3 offered to heat up R1's food when resident became "uncontrollable" and was "screaming and throwing trays." V3's note then indicated that resident went to his room and called the police then was taken to the local hospital. Note also included the following statement, "physical confrontation with the other resident" with no further details documented.

R1's nursing progress note dated 03/03/2024 03:46 submitted by V4 (Registered Nurse) indicated that R1 was admitted to a local hospital with the diagnosis of an alleged assault.

On 03/04/2024, reviewed facility investigation reports submitted to the department of public health by the facility from 12/2023 through current with no investigation report found for R1.

On 03/04/2024 at 1:58 PM, V2 (Director of Nursing) said she was informed by V3 (Registered Nurse) that on 03/02/2024, R1 had come out of his room to warm up some food when R1 became agitated with V3, R1 then called the police and was transferred to the hospital. V2 (DON) said she believed, being told by either V3 (RN) or V4 (RN), that R1 had been fighting with someone, whom she assumed was either with the emergency medical technicians (EMT's) or the emergency room staff.

On 03/04/2024 at 2:33 PM, V4 (Registered Nurse) said on 03/02/2024, she had received shift-to-shift report from V3 (Registered Nurse) who indicated that R1 was "being aggressive" and that the resident was sent to the hospital. V4 (RN) added that she could not recall whether V3 indicated that there was any type of a physical

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altercation with R1. V4 (RN) then said she followed up with the hospital and was told by the emergency room staff that R1 was admitted for an alleged assault. She added that no further details were communicated, nor did she ask for any additional information. V4 (RN) then said that she informed V2 (DON) of R1's status.

Reviewed R1's hospital paperwork dated 03/02/2024 that indicated R1 was seen in the emergency room and reported being hit to the head, neck and back areas by a male nurse at the facility. R1 also said he was pushed by this same nurse and sustained an injury to his right finger and complained about pain to the back of his head, neck and ribs. Hospital assessment revealed no aggressive behaviors, generalized tenderness to back of head, mid spine, right shoulder area and lateral chest along with an area of torn skin to his right ring finger. R1's diagnostic results showed a "fracture to right third digit." No aggressive behavior documentation was found within R1's hospital paperwork.

On 03/05/2024 at 10:43 AM, R4 said R1 was his roommate and that they both recently had admitted to the facility. R4 then said on the morning of 03/02/2024, he was in his room and could hear what sounded like an altercation in the hallway. He then said a few minutes later, R1 came into the room and called the police from his cell phone and reported being assaulted by a male nurse. R4 then said later the day and the following day, some staff were talking to him about the incident and said V3 and R1 had gotten into a fight where R1 punched V3 several times and V3 had punched R1 once or twice.

On 03/05/2024 at 11:07 AM, V3 (Registered Nurse) said on day of incident, R1 became upset

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when he (R1) couldn't heat up a container of food by himself. V3 said after he assisted R1's with his food, R1 went back to his room but shortly after, came out of his room and tried to get on the elevator to smoke but the elevator was full. V3 said R1 began throwing breakfast trays and items from these trays when he (V3) physically took R1's hands from the tray cart and placed them on his walker because R1 appeared unsteady on his feet. V3 (RN) then said R1 calmed down and went back to his room. When asked to clarify the "physical confrontation with the other resident" from his progress note dated 03/02/2024, V3 said some residents had come out of their rooms when R1 was yelling and throwing trays down the hall near them but no contact was made. He added that at no time was there any physical confrontation between R1, himself or any other resident. V3 (RN) then said the police came shortly after and asked for R1 so he (V3) took them to R1's room where he was sitting on his bed eating. V3 (RN) said he did not notice any injury or bleeding to R1, but the police informed him that R1's hand was bleeding so he (V3) left the room to get supplies from his med cart and when he returned, the police and R1 were both gone. V3 added that one officer stayed behind to get R1's resident information and he (V3) asked this officer why they were taking R1 from the facility but V3 was only informed that the resident (R1) had called them. V3 (RN) then said he called V2 (Director of Nursing) and informed her about the incident, R1's behaviors, and that the police took R1 to the local emergency room.

On 03/05/2024 at 12:15 PM, V2 (Director of Nursing) said there is video surveillance in the hallways including on the second floor but, she would need to check if they are working because the last that she knew, they were not working.

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S9999	Continued From page 5 Surveyor requested to review video surveillance if available at this time. On 03/05/2024 at 1:48 PM, attempted to call R1's provided cell phone number. No answer, detailed message was left. On 03/05/2024 at 1:57 PM, V7 (Certified Nursing Assistant) said on 03/02/2024 she worked with V9 (Agency Certified Nursing Assistant) on the second floor. V7 added that she observed R1 trying to heat up some food, but the "second floor male African nurse" (V3) was being extremely aggressive verbally to R1. V7 (CNA) added that V3 was trying to tell R1 to use another microwave but R1 did not want to do so and R1 was telling the nurse (V3) to leave him alone. She then said a loud verbal altercation between this nurse (V3) and R1 began and was loud. She then witnessed this male nurse (V3) and R1 hitting each other with closed fists to the upper body, and the nurse was trying to shove R1 back into his room. V7 (CNA) added that she has never seen anything like this incident before and couldn't believe how comfortable the nurse (V3) seemed to be fighting with R1 in the open. She then said about 10-15 minutes after incident, the front desk called the unit indicating that the police were in the building who then left the facility with R1. V7 also said through her agency's app, employees can leave a review for a facility and indicated there were multiple reviews about a "second floor male African nurse" for this facility that is very rude. She added that she left a review stating this male nurse (V3) had fought with a resident in the hallway and that V9 may not want to say anything about the incident so she can continue working at the facility and not be put on the do not return list. On 03/05/2024 at 2:33 PM, surveyor met with V1	S9999		

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S9999	Continued From page 6 (Administrator) and V2 (Director of Nursing) regarding concerns with R1's and the status of video surveillance review. V1 said the video surveillance has not been working since she started almost two months. At 2:32 PM, V2 (DON) aid after being informed by V4 (RN) of R1's admitting diagnosis, she didn't believe the assault had occurred at the facility, and she thought it had occurred with the EMT's or in the emergency department. At 2:35 PM, V1 said to V2, "why didn't you tell me"!?! V1 then said she should have been contacted immediately after R1's diagnosis was obtained because it is considered abuse. V1 then said she would have sent the nurse (V3) home and initiated an abuse investigation. At 3:37 PM, V1 (Administrator) said she suspended V3 (RN) and has submitted an initial report to the department. V1 provided surveyor with copy of initial report which indicated she was made aware of an alleged abuse allegation by surveyor on 03/05/2024 that involved V3 (Registered Nurse) and R1; V3 was suspended pending investigation. On 03/06/2024 at 12:15 PM, V9 (Agency Certified Nursing Assistant) said she worked at the facility on 03/02/2024. She added that during the passing of morning trays, a resident, who she was unable to identify by name, had gotten upset because he wanted more coffee. V9 then said this resident began "slinging food trays" when a male nurse verbally asked him to stop then she saw this same nurse take the tray away from the resident. V9 (CNA) said that she did not see any type of physical altercation between the nurse or resident, she just heard a loud commotion while passing trays to other residents in their rooms. She then saw the police coming off the elevator and a few minutes later take this same resident off the unit.	S9999		

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S9999	Continued From page 7 On 03/06/2024 at 2:10 PM, attempted to call R1's cell phone number a second time. No answer, detailed message was left. Requested abuse screen for R1 from facility. As of 03/06/2024 at 03:04 PM, no abuse screen was provided, and no abuse screen or care plan were found in R1's medical records. On 03/12/2024 at 10:12 AM, V1 (Administrator) said based on the information received during this complaint investigation, she has terminated V2 (Director of Nursing) and will be terminating V3 (Registered Nurse). On 03/12/2024 at 10:15 AM, V11 (MDS Coordinator and Restorative Director) said she is not aware of any abuse screens or of the process in which quarterly/annual screening of residents for abuse is performed. On 03/12/2024 at 1:13 PM, V12 (Medical Doctor) said he saw R1 on the day of incident (03/02/2024) that led to R1 being sent out to the emergency room. V12 then said when he saw R1, the resident was "nice and calm, talked pleasantly, and displayed no behaviors." V12 added that his size and stature that can be intimidating to some people. V12 also said that no behaviors were reported to him by the facility staff regarding R1 while he (V12) was at the facility, and that R1's behaviors "began while at the hospital." (No documentation was found regarding the above mentioned encounter between V12 and R1). Reviewed facility abuse prevention program policy last revised 01/2019 that reads in part:	S9999		

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S9999	Continued From page 8 Policy: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a third party. III. Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics: staff obligations to prevent and report abuse, neglect, exploitation, mistreatment, any crime against the resident, theft and how to distinguish theft from lost items and willful abuse from insensitive staff actions that should be corrected through counseling and additional training. Staff should report their knowledge of allegations without fear of reprisal. how to assess, prevent, and manage aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff. what constitutes abuse (physical, mental, sexual, verbal), neglect, exploitation, mistreatment, and misappropriation of resident property. an employee's obligation under the law (Elder Justice Act) for reporting a suspected crime to the facility, the sate survey agency, and local law enforcement; the time frames for reporting; and management's obligation to prohibit retaliation against anyone who makes a report. V. Identification of Allegations/Internal Reporting Requirements:	S9999		

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Employees are required to immediately report any incident, allegation, or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to the Director of Nursing (DON). Any incident, allegation, or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident is reported to a covered individual; covered individuals are notified annually of these reporting requirements.

Supervisors shall immediately inform the administrator or in the absence of the Administrator, the DON of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, misappropriation of property, mistreatment or a crime against a resident. Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation.

VII. Prevention:

The facility desires to prevent abuse, neglect, exploitation, misappropriation, and a crime against a resident by establishing a resident-sensitive and resident-secure environment. This will be accomplished by a comprehensive Quality Assurance Performance Improvement approach.

Abuse and Crime Reporting:

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Policy: This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends or other individuals.

All personnel must promptly report any incident or suspected incident of resident abuse, mistreatment, neglect, or exploitation including injuries of an unknown origin.

All personnel, residents, visitors, etc. are encouraged to report incidents of resident abuse, mistreatment or neglect or suspected abuse, mistreatment or neglect, without fear of retaliation or retribution from the facility or its staff.

For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain:

1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, psychosocial well-being.

Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

4. Physical abuse: hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

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