STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008726	A. BUILDING: _____ B. WING _____	C 04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LAWN SHELTERED CARE	512 SOUTH FRANKLIN BUNKER HILL, IL 62014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2443208/IL172294 - Section 330.4240 cited.	S 000		
S9999	Final Observations Statement of Licensure Violations 330.4240a) 330.4240b) 330.4240c) 330.4240d) 330.4240e) Section 330.4240 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) (A, B) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence,	S9999		

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S9999	Continued From page 1	S9999		

that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to properly investigate and report verbal abuse investigations for R2, R4, and other unnamed residents. This failure has the potential to affect all 40 residents of the facility.

Findings include:

On 4/29/24 at 9:45 AM R2 stated, V2 (Nurse Aid-NA) bullies her about her having too many clothes and too much laundry.

On 4/29/2024 at 9:54 AM, R2 stated, V2 and V3 (NA's), "Gang up and demean me, especially when it comes to my clothes. R2 stated, she got new clothes at the clothing pantry and wanted them washed prior to wearing them. R2 stated, "V2 came bitching at me about 14 outfits. Saying I put too much in there. Two or Three months ago, (V3) threatened me. She said, if I don't quit putting so many clothes in the laundry, she was going to take all the clothes, (a former staff member) gave me, lock them up, and leave me with nothing to wear but my birthday suit." R2 stated she reported this to V1 (Administrator) and V1 told them, (V2 and V3) to back off and leave her alone. V2 added, "(R5) threatens to beat me up. I try to go to (V2) about it and she says, 'I don't care'." R2 stated she has witnessed staff mistreat R1 and R3 by threatening them or

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denying them from seeing the Doctor, to get adjustments to her medication. R2 stated she has heard staff use words such a "Smart ass" and "Bitch".

On 4/29/24 at 10:40 AM, V1 stated that she has had several residents complain to her about V2 raising her voice and cursing at the residents. V1 stated she could not recall the residents that have complained to her about V2 cursing at them, nor could she recall the specifics of the allegations. V1 stated she has spoken to V2 about her raising her voice and cursing at the residents. V1 stated she did not give V2 a written discipline nor did she suspend V2. V1 stated she did not conduct a formal investigation, nor did she report the allegations made by facility residents against V2.

On 4/29/2024 at 10:40 AM, V1 stated she had received complaints about V2. V1 stated, "In (V2's) defense, they do me the same way. They don't wait, they just start complaining to me right when I come in the door. They will go up to (V2), but she may be in the middle of something, so she probably is short with them. They are usually asking about Doctor or Dentist appointments. They complain about the fact that she doesn't respond and raises her voice. I don't know exactly what they say, she says, but they imply. From what I understand she raises her voice at them. I tried to tell her 'You can't raise your voice'. They have also come to me and said (V2) would not make them a Doctor appointment. I don't believe she would threaten them. I have not heard her cursing, but I have had that complaint over a period of time. I don't know any specifics, but I did talk to her about it." V1 continued to state, "When I get in the door, they rush me. I probably should have reported it (to IDPH), but I didn't hear it. I've had other employees tell me, maybe (R3). (V2)

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probably did lose her cool."

On 4/29/2024 at 11:23 AM, V2 denied being aware of any residents complaining about V2 to V1. V2 stated if she suspected abuse, she would call V1 and V1 would do what she needed to do.

On 4/29/2024 at 11:45 AM R4 stated, "V2 just yells, and a lot of people are tired of it. I think she was brought up yelling and screaming. She (V2) is very demanding. 4-5 residents are mad at (V2) because she's mean."

On 4/29/2024 at 12:12 PM, V1 stated, "Oh, I've had allegations. That can go in one ear and out the other, depending on who it is. I have never witnessed anything, just hear about it."

The Facility's Room Assignments sheet, undated, documents, there are 40 residents residing in the Facility.

On 4/29/2024 at 12:51 PM, V2 verified the undated Room Assignment Form provided was for the current dated of 4/29/2024.

On 4/29/2024 at 1:31 PM, V2 was observed still in the patient care area giving report to the next shift.

The Facility's Reporting Abuse to State Agencies and Other Entities/Individuals, dated 10/99, documented 1. Should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported. The Facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: a.) The State licensing/certification

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S9999	Continued From page 4 agency responsible for surveying/licensing the facility; b.) the local/State Ombudsman; c.) The Resident's Representative (Sponsor) of Record; d.) Adult Protective Services; e.) Law Enforcement Officials; f.) The Resident's Attending Physician; and g.) The Facility Medical Director. 2. Verbal/written notices to the above agencies will be made within 24 hours of the occurrence of such incident and such notice may be submitted via US mail, special carrier, fax, e-mail, or by telephone. Notices will include, as a minimum: a.) The name of the resident; b.) The number of the room in which the resident resides; c.) The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.), d.) The date and time the alleged incident occurred; e. The name(s) of all persons involved in the alleged incident; and f.) What immediate action was taken by the facility. 3. The administrator, or his/her designee will provide the appropriate agencies/individuals listed above with a written report of the finding of the investigation within 7 days of the occurrence of the incident. 4. Should the findings reveal that abuse did occur; the written report will include the corrective actions taken by the facility to prevent abuse from recurring. 5. Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse. 6. Inquiries concerning the reporting of abuse to State agencies should be referred to the administrator. (C)	S9999		