STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007231	A. BUILDING: _____ B. WING _____	C 05/14/2024

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S 000	Initial Comments Complaint Investigation 2413598/IL172872 Complaint Investigation 2413591/IL172879	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.690a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. These Requirements were Not Met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident was not injured during care for 1 of 3 residents (R2) reviewed for nursing care in the sample of 10. The findings include: R2's summary sheet showed R2 was an 89-year-old female. R2's 5/7/24 at 5:20 AM, progress note authored by V3 Registered Nurse (RN) showed he went to administer R2's narcotic before she got up and R2 said she thought her pinky was broke. R2 said she caught it when they threw her into bed last night. This note showed R2's right pinky finger	S9999		

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S9999	Continued From page 1 was swollen and deformed. On 5/10/24 at 10:20 AM, R2 was in her chair in her room. R2 was alert and oriented. R2's speech was clear and her color was fleshtone. There was a splint on R2's right fifth finger and a red wrap around the hand. R2 said on 5/6/24 she was sitting on the edge of her bed and the girl she identified as V17 Certified Nursing Assistant (CNA) grabbed her legs and threw her into bed. R2 said she thought she was going to fall so she grabbed for the handrail. R2 said her right pinky finger got twisted in it. R2 said she said my God! You broke my finger to the two staff present. They thought it was a joke. R2 identified V18 as being the other CNA present. I called my daugther in law (V5) and told her what happened. On 5/10/24 at 9:40 AM, V1 Administrator said two Certified Nursing Assistants (CNAs), V17 and V18, were helping R2 to bed and R2 grabbed the bedrail and thinks she caught her finger underneath. V1 said they didn't know about the injury until the next morning. At 9:59 AM, V3 Registered Nurse (RN) said on 5/7/24 at 5:20 AM, he went in to give R2 her morning pain medicine before she got up. R2 told him her pinky hurt more than her legs that morning. R2 told V3 she thought they broke her pinky when they threw her into bed last night. "She (R2) later told me she thought she caught her finger in the side rail. I spoke to (V5), (R2's) power of attorney (POA). (V5) said (R2) called her last night (5/6/24) and told her she thought they broke her finger when they helped her into bed." V3 said he went to the nurses' station and told the staff of his findings. V3 said V17 Certified Nursing Assistant (CNA) was present and had "a deer in the headlights look" and said nothing.	S9999		

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At 10:40 AM, V6 CNA said the CNAs that "did that to (R2) have been a lot rougher with the residents. They knew she was hurt and didn't report it. Most of the residents here are confused but (R2) can tell you what happened. (R2) told me who did it and how it happened."

At 10:55 AM, V10 CNA said on 5/6/24, R2 told her the boyfriend and girlfriend (referring to V17 and V18) threw her into bed (on 5/6/24) and caught her finger. R2 told V10 she told them she was hurt, and they didn't do anything. V10 said V3 told us while we were in report (the morning of 5/6/24) about R2's injury and V17 "looked scared." V2 Director of Nursing (DON) called me into her office on 5/6 or 5/7/24 to discuss my attendance and I told her what R2 had told me.

At 11:08 AM, V2 DON said there were no complaints or concerns about V17 or V18's care to the residents. V2 said the floor nurses should be monitoring resident care and report any concerns to me. V2 said she and V1 Administrator interviewed R2, V3 RN, V8 nurse, V17 CNA, V18 CNA, V19 RN, V20 CNA, V28 CNA, and R4 and R5.

At 11:30 AM, V11 Licensed Practical Nurse (LPN) said V17 is very defiant. V17 and V18 became an item about five months ago. They hold hands, V17 sits on V18's lap in front of the residents. They were caught making out in the stairwell by a nurse. The residents know they are an item. R2 told me they were rough with her. If R2 said that's what happened, "I absolutely believe her." R2 can have some confusion but she's more with it than not.

At 11:56 AM, V12 CNA said R2 told me they were

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rough, pushed her into bed and wouldn't get the nurse when she complained of pain. R2 is very with it.

At 12:23 PM, V14 LPN said she had spoken to both V17 and V18 about changing the assignments. They seem to feel they need to work together. They put people to bed too soon, sometimes by 5:30. V14 said she wasn't there when R2's injury happened but "if you start rushing, that's when things are going to happen". R2 told me they threw her into bed by 5:30 PM and this is what happened.

At 1:20 PM, V5, R2's POA said on 5/6/24 she missed a call from R2 at 5:37 PM. V5 said she returned the call at 5:43 PM. V5 said R2 was upset and told her that a girl and a guy that are a couple tossed her into bed and hurt her finger. V5 said R2 told her R2 yelled at V17 and V18 that they broke her finger and again told them a second time before they left the room. If R2 said that's what happened, I believe her. R2 is not one to exaggerate. R2 is usually more afraid of saying anything. I told R2 to tell the nurse. The way she described it, I have no doubt, I am 100% sure the transfer caused the injury. R2 was nervous about how they handled her. R2 told her they play hanky panky and ignore her. R2 said she was scared and nervous and somehow her finger got caught. V5 said there would have been nothing to have necessitated tossing her around. R2 is very nice and had no behaviors. R2 would be more afraid that you'd be mad at her if she said anything.

At 1:57 PM, V4 Nurse Practitioner said she was told by the nurse R2's finger got caught in the bedrail at night. If she was tossed into bed, it probably caused the injury. R2 said the staff were rough, she reacted scared, and her finger got

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S9999	Continued From page 4 caught. At 2:17 PM, V17 CNA said there had been no concerns of her rushing through care or being rough. V17 denied being distracted at work. V17 said she and V18 transferred R2 "like normal" and R2 never complained of injury or pain. At 2:28 PM, V18 CNA said on 5/6/24, he and V17 uneventfully transferred R2 to bed. V18 denied being distracted, rushing care or any injury or pain complaints by R2 that night. On 5/13/24 at 10:34 AM, V19 RN said she was on duty the night shift of 5/6/23 and she did not provide care to R2 and was not notified of any concerns for R2. At 11:00 AM, V22 CNA said on 5/7/24, R2 said she said something right away about being hurt and then called V5. R2 said she was in bed by 5:30 PM, named the staff members who did it and said what happened. "Yes, I believe (R2)." On 5/14/24 at 8:43 AM, V30 Activity Aide said R10 complained in resident council on 4/25/24 about V17 and V18's care being rushed. V30 said R10 said "they're in such a dang hurry." At 1:00 PM, V21 CNA said on 5/7/24 she was orienting V27 CNA. They both provided care for R2 that day. R2 told them she was scared and said she thought they broke her finger. She identified V18 and the girlfriend as who did this to her. R2 said V17 and V18 went to throw her in bed, and she told them she thought they broke her finger. She is worried and was crying they are still working here. We feel like this is being covered up. R2 is a quiet person, avoids issues and does not stir the pot. I believe her. When V17	S9999		

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and V18 work together, they're not worried about work. They hurry and toss people into bed. They should have just said something when it happened. They want the work done so they can visit.

R2's face sheet showed she required 2 staff to assist with transfers.

The facility's resident census showed R2 was interviewable.

R2's 5/6-5/7/24 progress notes had no documentation of an injury occurrence.

R2's care plan showed a history of anxiety and to maintain a clam and comforting demeanor when working with the resident and interact with the resident in a peaceful manner.

R2's 5/7/24 5:20 AM nurse progress note showed R2 told V3 Registered Nurse (RN) she thought her pinky was broke. R2 said she caught it when they threw her into bed last night. This note showed R2's right pinky finger was visibly swollen and deformed.

R2's 5/7/24 incident/accident report showed the resident reported she thinks they broke her pinky when they threw her into bed last night.

R2's 5/7/24 right hand x-ray report showed a non-displaced acute fracture at the base of the fifth (pinky) finger.

V4's (nurse practitioner) 5/13/24 visit note showed a closed nondisplaced fracture of the base of the fifth metacarpal bone of the right hand. (This note showed she was notified 5/6 and will be amended to reflect the correct date of

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S9999	Continued From page 6 5/7/24). This note showed the nurse informed her the injury happened when staff were getting her into bed (on 5/6/24). R2's care plan showed she had left hip pain due to severe osteoarthritis and takes scheduled acetaminophen, hydrocodone, gabapentin and diclofenac. The facility's incident investigation about the occurrence on 5/6/24 showed R2 told V1 and V2 that V17 and V18 threw her into bed causing her injury. R2 said she felt like she was falling as V17 brought her feet around fast. R2 said she grabbed for the bedrail and thought she got her pinky finger caught. R2 said she felt they wanted to get done so that they could go on to other things. R2 told V1 and V2 she told V17 and V18 her finger was hurt, and they did not respond. R2 said she felt like it was an accident from carelessness. The investigation showed no findings of abuse or neglect. The facility's CNA schedule showed V17, V18, V24 and V25 worked the evening shift on 5/6/24. The facility's Abuse Policy updated 2023 showed all residents of Parkview Home have the right to be free from abuse, neglect, mistreatment, corporal punishment, misappropriation of their personal property, exploitation and/or involuntary seclusion. Accordingly, Parkview Home hereby prohibits the abuse, neglect, mistreatment and corporal punishment of its residents and/or the misappropriation of their personal property. It is the responsibility of all facility employees to assure that residents' rights are protected by reporting all incidents or occurrences (or potential occurrences) of Abuse, Neglect, Exploitation and/or Misappropriation of Resident Property to	S9999		

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S9999	Continued From page 7 their direct supervisor or to the facility Administrator. All facility employees are required to report all resident incidents and/or accidents, including minor bruising and skin tears immediately, to their direct supervisor, if available, or to another management level employee. Employees are further required to report any occurrences of potential mistreatment that they observe, hear about or suspect immediately to their direct supervisor. The employee forming the suspicion must also immediately report the concern to the Administrator or Director of Nursing unless their supervisor immediately reports the allegation to the Administrator or Director of Nursing. The initial person receiving the allegation also needs to put in writing what was reported to them. Supervisors are required to immediately inform the Director of Nursing or the Administrator of all reports of potential Abuse, Neglect, Exploitation and/or Misappropriation of Resident Property. Incidents and accidents include, but are not limited to, situations or allegations which, if true, could constitute as Abuse, Neglect, Exploitation and/or Misappropriation of Resident Property. Upon learning of a suspected incident or accident, whether through a report or otherwise, the Director of Nursing or the Administrator will initiate and supervise the incident investigation. The Investigator will review all documentary and physical evidence, if any. If the incident/accident involves an injury of unknown origin, the Investigator will consider and suggest factors that may have contributed to the injury. Investigations will be conducted, to the extent possible under the circumstances, in a confidential manner. The identities of any employees or residents involved in the investigation will be protected, if possible, until the investigation is concluded. Investigations will be conducted as expeditiously as possible,	S9999		

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and in no event shall an investigation take longer than three working days to conclude. The Investigator will update the Administrator or Director or Nursing during the progress of the investigation as appropriate.

The facility's 5/31/19 Resident Change in Condition Policy showed any resident change in condition must be reported to the resident's Power of Attorney (POA) and a call must be placed to the resident's physician or on call physician, if their primary is not available. This change in condition must be reported by the nurse who is on duty when the change in condition is first noted, be documented in the resident's chart and passed on to the next shift in report. This includes falls and any worsening of any condition that may need intervention or treatment put in place. Even if the resident or any other person has been in contact with the POA, a nurse must call and update them with any change in condition.

The facility's 6/15/2012 Change in Condition Family/Power of Attorney Notification Policy showed family and/or POA ae notified anytime there is a change to a resident's condition. From 0800 to 2200 (10:00 PM) notification of any change in condition will be done in a timely manner. Notify party specified on the summary sheet. Document in the medical record the date, time, person spoken with, what was reported and their response if any.

The facility's 6/15/2012 Change in Condition Physician Notification Policy showed the attending physician or physician on call is to be notified of any change in condition/health status. From 0800 to 2200 attending physician or on call physician is to be notified of all condition or health

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S9999	Continued From page 9 status changes. From 2200 to 0800 the attending physician or physician on call should be notified of any change in condition, health status or incident that resulted in an injury that has the potential for physician intervention. (B) Statement of Licensure Violations (2 of 2) 300.3240a) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview, and record review, the facility failed to investigate injuries of unknown origin and an allegation of rape as potential abuse for 2 of 3 residents (R1, R3) reviewed for nursing care in the sample of 10. The findings include: 1. R3's summary sheet showed a 100-year-old female with diagnosis of altered mental status, dysphagia, anxiety disorder, cervical disc degeneration, dementia, stage 3 kidney disease, and insomnia. On 5/10/24 at 11:00 AM, R3 was in a high back reclining chair in the dining room. R3 had a raised bruise to the middle of her forehead. On 5/14/24 at 9:52 AM, R3 was in her chair near the nurse's station. The bruise to her forehead was darker purple and no longer raised. On 5/10/24 at 10:40 AM, V6 Certified Nursing Assistant (CNA) said about three weeks ago R3	S9999		

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had a bruise to the left side of her neck. It looked like she might have been grabbed. V6 said on 5/5/24 she saw V18 CNA come out of R3's room with a total mechanical lift by himself. I did not help him. He put her to bed by himself. The next day the hospice aide found a bruise to her head. I told V2 Director of Nursing (DON) and V9 Registered Nurse (RN) about it. V9 texted me that he did not observe the transfer but told management he did. V6 showed this surveyor the text message from V9 which did indicate he did not observe R3's transfer but he said otherwise. V6 said the DON said she would "reeducate" V18. V6 said she worked the following day and V16 hospice CNA noted a bruise to R3's eyebrow and the nurse was notified.

At 11:08 AM, V2 DON said there were no complaints or concerns about V17 or V18's care to the residents. V2 said the floor nurses should be monitoring resident care and report any concerns to me. If there was an injury of unknown origin (IUO) it should be investigated, interview the resident, notify the power of attorney (POA) and provider, and interview anyone who worked with the resident for the prior three shifts. R2 was the only IUO investigated recently. It's important to investigate IUOs to rule out abuse and prevent it from reoccurring.

At 11:30 AM, V11 Licensed Practical Nurse (LPN) said on 5/8/24 she sent a picture of R3's thighs to V2 DON and V4 Nurse Practitioner (NP). V17 and V18 had provided care to R3 the prior day. There was finger like bruises to both of R3's thighs. I am suspicious of any bruises after V17 and V18 care for the residents although I have not witnessed them being rough. "I don't trust them with the residents." So many things have been reported to V1 and V2 and it's being ignored for some

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S9999	Continued From page 11 reason. At 11:56 AM, V12 CNA said I have seen them (V17 and V18). They were rude and refused to train a new aide. I try to assign them to different units but the nurse or they change the assignments. R2, R6, and R7 have complained about them. R2 told me they were rough and pushed her into bed and wouldn't get the nurse when she complained of pain. R2 is very with it. R6 said they were rough with her and asked me to tell them not to be mean to her. R7 fears them and asked for other CNAs to care for her. R3 had an unexplained bruise to her face within the last week. V18 did a total lift transfer on her by himself. He had the nurse (V9) say he watched but he didn't. V2 said either on 4/30/24 or 5/1/24, she spoke to V1 about her concerns of them (V17 and V18) working together, changing the schedules, and being too rough and spoke to V2 on 5/7/24. At 12:23 PM, V14 LPN said she had spoken to both V17 and V18 about changing the assignments. They seem to feel they need to work together. At 12:33 PM, V15 RN said V17 and V18 get to do whatever they want. The schedule is switched so they can work together. Recently, R3 had a bruise on her head found by hospice after they cared for her. At 12:53 PM, V16 hospice CNA said on 5/6/24 around 10:30 AM, she noticed a new bruise to R3's brow. At 12:53 AM, V23 hospice nurse said on 5/6/24 she noted a new bruise to R3's brow and wrist. V23 said she notified the facility nurse and "I think	S9999		

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S9999	Continued From page 12 it was the first time they had heard of it". R3 had some marks that looked like fingers on her thighs. R3 hasn't had any injuries so they may be from rough care or abuse. On 5/14/24 at 8:30 AM, V1 Administrator confirmed that R2's injury and a CNA using foul language were the only two abuse investigations in the past three months. At 11:36 PM, V1 and V2 said they were not aware of any unexplained bruises to R3, and they hadn't investigated any. At 1:00 PM, V21 CNA said R3 had some weird finger like marks on her upper legs. They're not there now. She had some suspicious bruising to her forehead as well. I told the nurse about it Saturday (5/4/24). The facility's Abuse Policy updated 2023 showed, All facility employees are required to report all resident incidents and/or accidents, including minor bruising and skin tears immediately, to their direct supervisor, if available, or to another management level employee. Employees are further required to report any occurrences of potential mistreatment that they observe, hear about or suspect immediately to their direct supervisor. The employee forming the suspicion must also immediately report the concern to the Administrator or Director of Nursing unless their supervisor immediately reports the allegation to the Administrator or Director of Nursing. The initial person receiving the allegation also needs to put in writing what was reported to them. Supervisors are required to immediately inform the Director of Nursing or the Administrator of all reports of potential Abuse, Neglect, Exploitation and/or Misappropriation of Resident Property.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007231	A. BUILDING: _____ B. WING _____	C 05/14/2024

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S9999	Continued From page 13 Incidents and accidents include, but are not limited to, situations or allegations which, if true, could constitute as Abuse, Neglect, Exploitation and/or Misappropriation of Resident Property. Upon learning of a suspected incident or accident, whether through a report or otherwise, the Director of Nursing or the Administrator will initiate and supervise the incident investigation. The Investigator will review all documentary and physical evidence, if any. If the incident/accident involves an injury of unknown origin, the Investigator will consider and suggest factors that may have contributed to the injury. Investigations will be conducted, to the extent possible under the circumstances, in a confidential manner. R3's 2/17/24 nurses notes showed Certified Nursing Assistants (CNAs) reported a skin tear to the right forearm and bruises to both forearms. This note showed bruises to both forearms and right hand. R3's 4/14/24 nurse note showed CNA reported a new bruise to the right side of her neck. Bruise purple in color and the size of a thumbprint. Director of Nursing (DON) notified. A later 4/14/24 nurse note measured the neck bruise as 5.2 centimeters (cm) X 2.1 cm. Charge nurse informed. Will also notify DON. R3's 5/6/24 nurse note showed CNA staff noted a new bruise on the left eyebrow. DON notified. R3's 5/8/24 nurse note showed bruises in various stages of healing to both thighs. R3's physician orders showed aspirin 81 milligram chewable tablet as the only blood thinning medication prescribed.	S9999		

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S9999	Continued From page 14 R3's 4/28/24 facility assessment showed she was totally dependent on two plus persons to transfer and required extensive assistance of two plus person for bed mobility. R3's hospice care plan showed to check skin with cares and report any abnormalities. R3's 5/6/24 hospice CNA note showed she noted a bruise to R3's left eyebrow. R3's 5/6/24 hospice nurse note showed new bruises to R3's right wrist, hand and a small bruise to the eyebrow were observed. R3's hospice care plan showed to check skin with cares and report abnormalities. 2. R1's summary sheet showed an 80-year-old female with diagnosis of vascular dementia, hypertension, syncope, uterine cancer, long term use of anticoagulants, and mild protein malnourishment. On 5/10/24 at 10:35 AM, R1 was assisted from a recliner near the nurses station to a standing position. R1 was assisted to walk with a walker to the dining room. R1 did not speak and was calm and alert. R1 followed the staff members directions and no behaviors were noted. On 5/14/24 at 8:50 AM, V29 and V30 Activity Aides said on 5/3/24 R1 had an issue with V18 Certified Nursing Assistant (CNA). R1 was terrified of him. R1 told us that V18 did inappropriate things to her and raped her. V29 said she and V30 reported it to V15 Registered Nurse (RN) that day. V30 said R1 was tearful and crying. In R1's mind, it really happened. V29 and	S9999		

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S9999	Continued From page 15 V30 said they rolled R1 around with them all day long. At 12:30 PM, V1 Administrator said activities reported R1's allegation to social services. There was no documentation anywhere of the allegations. This should have been investigated. V2 said R1 had no documented behaviors of this sort. At 12:32 PM, V2 Director of Nursing (DON) said she believed the night before, R1 thought her husband was in the building and trying to get her. V2 said she doesn't know if R1 had a history of abuse. V2 said these behaviors are not documented in a care plan or reflected in behavior monitoring. V2 said it's important to investigate abuse allegations and injuries of unknown origin to keep the residents safe. We must listen to the residents to understand if anything had happened. If abuse allegations are not investigated resident safety could be jeopardized. R1's progress notes dated 4/23-5/11/24 showed no documentation of a rape allegation or behaviors requiring 1:1 reassurance. R1's care plan showed a history of severe cognitive impairment, anxiety, and depression. There were no behaviors identified besides medication refusal, resistance to care, and attempts to self-transfer. R1's behavior monitoring showed hiding food items, tearfulness, refusing care/meds, insomnia, and self-transfers as known behaviors. There was no abuse investigation for R1's allegation of rape.	S9999		

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S9999	Continued From page 16 (B)	S9999		