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S 000	Initial Comments Complaint Investigation: 2493315/IL172467	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	S9999		

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care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to protect cognitively impaired residents from physical and verbal abuse; and failed to follow the facility abuse policy for two (R1 and R2) of three residents reviewed for abuse. These failures resulted in R1 and R2 being physically and verbally abused during provision of care. R1 and R2 were sent to the hospital for further evaluation and treatment and R2 sustained a right frontal hematoma and abrasion, left lateral periorbital ecchymosis and lower lip abrasion.

Findings include:

R1 is an 80 year old male, admitted in the facility on 02/19/24 with diagnoses of Delusional Disorders; Dementia In Other Diseases, Classified Elsewhere, Severe, with Psychotic Disturbance and Alzheimer's Disease, Unspecified. R1's MDS (Minimum Data Set) dated 02/22/24 recorded a BIMS (Brief Interview for Mental Status) score of 2 which means severe cognitive impairment. Social Services assessment dated 04/18/24 indicated R1 is at risk for abuse.

R1's care plans documented in part but not limited to the following:
Abuse (initiated 04/29/24): Interventions - Provide

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reassurance to R1 remind him that he is safe and secure.
Cognitive Loss (initiated 02/21/24): Intervention - Cue, reorient and supervise him as needed.
Behavior (initiated 02/28/24): Interventions: Approach in a calm manner; Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.

According to initial incident report dated 04/27/24, V16 (Family Member) notified V2 (Executive Director) that V5 (CNA Agency) assigned was verbally and physically aggressive towards R1 during care.

On 04/29/24 at 12:25 PM, V16 was interviewed regarding R1's alleged abuse allegation. V16 stated, "We installed a camera here in this room for him (R1)." A camera was observed installed by the television facing R1's bed. V16 continued, "I worked in healthcare management, and I know how it is if you live in a nursing home. V2 contacted me last Friday night (04/26/24) around 11:00 PM and asked if we could help her get video footage she needed. I emailed the footage at 12:14 AM, that was Saturday, and one minute later she responded that she received it. I called her back and informed her that there was an incident with R1 when a staff member brought him back to bed, that was around 9:31 PM. The staff was verbally abusive. It was caught on the video. She (V2) said she will do the investigation." During interview with V16, it was observed that a sign stated that there is an audio and video recording in R1's room posted at the door. Same sign was also posted at bedside visible to all staff and visitors.

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Electronic Monitoring Notification and Consent Form stipulated that V16 was permitted to conduct authorized electronic monitoring in R1's room through the use of an electronic monitoring device. It was signed and dated 02/24/24.

Video footage dated 04/26/24, time stamped 9:31 PM was seen, showing V5 was yelling, intimidating and aggressive with R1 while putting him back to bed. R1 was heard saying "You stop, stop, I said I'm not stopping" while V5 continued to yell telling him (R1) to lay down in bed. Video also showed R1 was pushed by V5 as she (V5) tried to make him (R1) lie down in bed.

On 04/29/24 at 1:55 PM, V6 (Registered Nurse, RN Supervisor) was asked regarding R1. V6 stated, "On 04/26/24 incident with V5, I was only told about the incident after V2 saw the video in the room."

On 04/30/24 at 10:58 AM, V4 (RN) was interviewed regarding knowledge of R1's abuse allegation involving V5. V4 replied, "Last 04/26/24, I was at the nurses' station and didn't hear V5 yelling or anything. I am not aware of any abuse incident on R1 with V5 who worked under me that night. That was my first time working with her (V5)."

On 04/30/24 at 10:17 AM, V2 was asked regarding R1's incident on 04/26/24. V2 replied, "When the police came in to investigate R2's abuse incident; and make a report after we called, they (police) attempted to interview R2. They noticed the sign that says video surveillance on R1. The police asked for us to contact the family of R1 to see if they are comfortable in providing them the clips related to care provided. I contacted V16 on 04/26/24 around 11:45 PM, to

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request video clips which she then provided at 12:15 AM on 4/27/24. She sent the clips via email. She called me the same time regarding a concern related to care provided by a staff member to R1." The CNA in R1's video footage was identified as V5, per V2. V2 also verbalized, "V16 stated, V5 appeared verbally and physically aggressive towards him (R1). At that point, I got off the phone, started the investigation. I immediately suspended her (V5). She is from staffing agency. That was the first time she (V5) picked up a shift for us. She (V5) was made aware that she is immediately suspended and will not be coming back to the facility. She (V5) was escorted out of the building and was deleted from the system. I also informed the agency to let them know that we had a serious abuse allegation on her (V5). I have had no contact with her (V5) afterwards. I attempted to interview him (R1), but he was confused and unable to provide details of what happened. He (R1) was sent to the hospital and came back with no injuries noted."

Hospital records dated 04/27/24 recorded that R1 was brought to the emergency department for alleged physical assault. That a staff member at nursing facility was allegedly caught on camera assaulting R1. R1 stated, "I hurt all over" unable to point to exact location of pain. R1 was complaining of right-hand pain. There were no visible injuries noted including bruising, abrasion or lacerations; and no fractures or dislocation found.

Progress notes dated 04/27/24 documented R1 came back to facility from the hospital.

On 04/30/24 at 12:30 PM, R1 was observed in his room, in bed. He is alert and oriented to self, and verbal. R1 was asked regarding incident on

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04/26/24 involving a staff member. R1 stated he does not remember any incident and has no issues with staff in the facility.

On 5/1/20 at 2:32 PM, V19 (Unit Care Assistant) was asked regarding R1 and V5. V19 verbalized, "On 04/26/24 around 9:32 PM, I saw V5 bringing R1 to room. I told her (V5) to handle R1 with care because there is a camera in his room. Since she (V5) does not know him, she walked him (R1) back to room, without letting him (R1) use the walker. She stood in front of him (R1), took both of his hands and guided him back to his room. She (V5) does not know R1, that he gets agitated easily, so she needs to be careful when she approached him."

Police Report dated 05/02/24 recorded an offense "Aggravated Battery" on R1 by V5. The incident was dated 04/26/24; and was reported to police 05/02/24. In the said police report, it was documented that R1 in this case is an additional victim from the same room at the facility and two incidents took place about 15 minutes apart. V2, apparently after seeing the video provided by V16, advised police that V5 was seen pushing R1 in the chest three times while telling him to lay back in his bed; R1 was sitting up in bed when he was pushed.

On 05/06/24 at 11:06 AM, V2 was asked regarding police report on R1. V2 replied, "I called police the night of the incident, on 04/27/24. They did not make the second trip because he (R1) was sent to the hospital."

On 05/06/24 at 12:35 PM, surveyor called V22 (Local Law Enforcement Agency) to clarify R1's abuse report. V22 stated, the police report states it was reported on 05/02/2024." Surveyor

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informed V22 that facility staff stated it was reported on 04/27/24 with the other allegation. V22 checked records, and stated, the abuse for R1 was only reported on 05/02/2024."

R2 is an 85 year old, male, admitted in the facility on 02/14/23 with diagnosis of Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, with other Behavioral Disturbance and Parkinson's Disease Without Dyskinesia, Without Mention of Fluctuations. MDS dated 02/29/24 recorded that R2 has BIMS score of 2 which means severe cognitive impairment. Social Services assessment dated 02/28/24 indicated R2 is at risk for abuse.

R2's care plans documented in part but not limited to the following:
Abuse (initiated 04/27/24): Interventions - Recognize that the resident (R2) is an adult living with chronic, debilitating comorbidities in a skilled care setting and may experience feelings of lack of control and powerless; Work with the resident (R2) to overcome these feelings; advocate for expression of resident rights, autonomy and encourage independent decision making; Provide positive encouragement, support and kindness.
Parkinson's Disease and is at risk for possible complications (initiated 08/11/23): Intervention - Allow sufficient time for speech/communication.
Cognitive loss (initiated 02/14/23): Intervention - Offer cues, direction and redirection as needed.
Behavior symptoms (initiated 02/21/23): Interventions - Behavior-Communication. Try to ascertain what the behavior is communicating. Why is it being displayed here/now? Why in front of these people? What is the resident trying to tell us? What motivates the person to act this way? Is the behavior related to modesty/possible embarrassment? Is it related to a possible history

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of trauma? What message or secondary gain is the resident seeking? What message is the person sending by rejecting care? Assure the resident that safety, security and dignity are paramount. What does the resident mean by statements that blame staff for personal poor choices?
Care rejection. Avoid Power Struggles. Build a relationship, rapport. Do not argue. If the present is not a good time for the resident, revisit the care situation later. It is ok to back off.
Episode of increase restlessness, anxiety, impulsive, short attention (initiated 05/19/23): Intervention - Monitor/record occurrence of behavior symptoms and document per facility protocol. Notify physician, family, nurse any changes.
On antipsychotic medications (initiated 03/28/23): Intervention - Care in pairs. Provide calm approach, explain in simple words task to be given. Allow time to understand.

Initial incident report dated 04/27/24 documented V2 was notified that V5 reported R2 was aggressive and combative during care. R2 represented confused and unable to recall.

Progress notes dated 04/26/24 time stamped 9:55 PM recorded that R2 was assessed, observed bleeding on the lips, bump, and scratches on forehead area.

On 04/29/24 at 1:55 PM, V6 was interviewed regarding R2's incident on 04/26/24. V6 stated, "I was initially called at 9:55 PM by V4 regarding R2. V4 noted that there were scratches on his (R2) forehead, bumps on both sides of forehead and bleeding on the lips. V4 said, V5 asked for a band aid at 9:52 PM for her injured finger, like a scratch. She (V4) provided the band aid and

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checked on R2 and noticed the injuries. She (V4) did his (R2) initial assessment and called me right away. I went into his (R2) room, V4 and V5 were at the nurses' station. I went directly to assess R2. I also noted the injuries. I instructed V4 to supervise V5 while I do my investigation. With my investigation, there was a possible abuse on him (R2), so I called V2. I was told that she (V2) is going to come. I assigned a different CNA on R2, first aid provided, instructed V4 to inform Hospice. V2 came around 10:30 PM so she did her investigation as well. She (V2) also called local police. She (V5) was also interviewed by V2. She (V5) was supervised and took her off from the schedule. When the police arrived, they did their track on R2, interviewed me, and V4. After that, they noticed that there was a camera in R1's bed, they requested surveillance. Police interviewed V5; took pictures of R2, and injuries of V5's hand. Police cannot arrest her (V5) at the time because R2 was confused and unable to narrate the incident. He (R2) is alert and oriented to self; unable to verbalize needs and dependent on staff for all care. He (R2) is also a hospice resident."

On 4/29/24 at 2:20pm V4 was asked regarding R2's incident on 04/26/24. V4 replied, "Around 9:30 PM, all residents were getting situated. CNAs are getting residents ready for bed. He (R2) was in his bed, in his room. I was at the nurses' station when V5 asked me for a band aid, said she had a scratch in her hand. I did not inspect her hand, but I gave her the band aid. I noticed that she was walking towards R2's room. I followed her and that was the time when I noticed that he (R2) had bleeding in his lips, saw bumps on his (R2) head and scratches that were starting to swell. I asked her (V5) on what happened, said he (R2) was resisting, and she

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(V5) was trying to get him dressed and ready when he started to kick and swung his arms and ended up hitting his head on the side rails. I told her (V5) to give me a second and will be back and that is when I contacted V6. In between that, I assessed him (R2), I cleaned his lips and forehead, assessed his range of motion and did neuro checks. V6 asked me to contact Hospice. Personally, when I worked with him (R2), he did not display any refusal to care or aggressive behavior. If a resident is refusing care at the moment, let them be, they have the right to refuse. Then come back at a later time, maybe after an hour and try to do the care. She (V5) did not tell me what happened. No, she didn't tell me about the behavior during care. She only told me when I went to the room and checked on him (R2). She (V5) should report the incident to me at the time, so I could assign another CNA to R2."

Electronic Monitoring Notification and Consent Form stipulated that V20 (Family Member) signed a consent form for R2's video and audio surveillance in the room. The consent was signed on 02/26/24.

R2 shared the same room with R1. R1 and R2 are residents in the facility's Dementia Unit. V5 was the assigned CNA for R1 and R2 on 04/26/24, from 3:00 PM to 11:00 PM.

In a video footage dated 04/26/24, time stamped 9:38 PM, it was seen in a partial angle view that R2 was sitting in the wheelchair. V5 was heard yelling, intimidating and verbally threatening R1, saying, "Stop, you need to, I'll punch your face like that. Stop." In another video footage dated 04/26/24, time stamped 9:39 PM, V5 was seen as she aggressively pulled R2's clothing. V5 was then heard saying "Stop."

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On 04/29/24 at 12:10 PM, R2 was observed in bed, alert, oriented to self, verbal. R2 was observed with multiple scratches on the forehead and a scratch on the left eye. A purplish discoloration was noted on the left eye and greenish to yellow discoloration above right eye. An abrasion was also noted to his lower lip. R2 was asked regarding injuries, stated, "I don't remember what happened." R2 was also asked if he went to the hospital, stated he does not remember.

On 04/30/24 at 10:17 AM, V2 was asked regarding R2. V2 stated, "As soon as V6 notified me at 10:04 PM to report concern regarding R2's injuries, I came to facility within 20 minutes. I advised him (V6) to keep an eye on V5. She (V5) was immediately separated from the residents and another CNA was reassigned to R2. When I interviewed her (V5) that night, she received a scratch from her middle finger from R2 as he (R2) was combative and aggressive during care by kicking and scratching. I saw the scratch from her (V5) middle finger. She (V5) said she was trying to remove his (R2) shirt and he was scratching and kicking her. He was still combative when he was in bed and sustained the injuries from the side rails and headboard. I told her (V5) that if a resident says no, she is supposed to give them time and report to the nurse and that maybe a different staff or CNA should be assigned. She (V5) should have reported his (R2) behavior to the nurse. He (R2) was sent to the hospital for further evaluation and management. She (V5) was made aware that she is immediately suspended and will not be coming back to the facility. She (V5) was escorted out of the building and was deleted from the system. I contacted V15 (Staffing/Schedule Coordinator) not to

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schedule her (V5). I also informed the agency to let them know that we had a serious abuse allegation on her (V5). I have had no contact with her (V5) afterwards. She (V5) is from s******* agency. That was the first time she (V5) picked up a shift for us." V2 was also asked regarding police involvement during investigation. V2 continued, "When the police came in to investigate and make a report after we called, they attempted to interview R2. They noticed the sign that says video surveillance on R1. The police asked for us to contact the family of R1 to see if they are comfortable in providing them the clips related to care provided. I contacted V16 last 04/26/24 around 11:45 PM, spoke and requested the video clips which she (V16) then provided at 12:15 AM. She sent the clips via email."

R2's Hospital Records dated 04/27/24 recorded in part but not limited to the following:
Chief complaint: Alleged Assault
Visit Diagnosis: Traumatic injury of Head, Initial Encounter
History of Present Illness: Presents to the emergency room brought in due to an assault. Patient (R2) was reportedly assaulted by a CNA at the nursing home prior to arrival. Patient (R2) suffered multiple head injuries after being hit in the head and face. On questioning the patient (R2), he does not recall what happened and is oriented to name only which is his baseline.
Physical Exam:
Head: Right frontal hematoma and abrasion, left lateral periorbital ecchymosis.
ENT: lower lip outer abrasion.
Emergency Department Diagnosis: Assault; Traumatic Injury of Head, Initial Encounter

Police report dated 04/26/24 recorded an offense

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"Battery Aggravated to Senior Citizen." Victim was R2 and V5 was the offender. Police report stated in part but not limited to the following: The incident occurred on 04/26/24 and was reported to police. Police responded, observed R2 with cuts on his head and lip. There was a blood stain on the wall above R2's bed and on his bed sheet. R2's hands were checked for blood or signs of injury. R2's right thumb nail appeared to have a crack in it with dried blood. Spoke with V5 who related she was preparing R2 for bed and transferring him out of his wheelchair and into bed. While doing so, V5 said R2 became agitated and flailed his arms and legs, causing a cut to her (V5) finger. V5 said she does not know how R2 got the cuts on his head and lip. V5 said he could have hit his head and lip on the bed board while he was refusing her care.

The police report also documented that three video clips were uploaded from R1's camera, narrating, "The first video shows V5 being aggressive with R2's roommate (R1). V5 tells him (R1) to lay his head down and she (V5) pushes him (R1) into the bed. The second video shows V5 partially out of frame and she says "stop" and appears to pull something out of R2's hands. The third video shows V5 partially out of frame and she says "stop."

On 4/29/24 at 1:00pm V2 was asked regarding screening and abuse orientation among agency staff working in the facility. V2 verbalized, "Agency staffing is ongoing. We make sure that agency provided us background checks. Prescreening is done through agency. Agency staff picked up a shift and we do onboarding orientation with Scheduler and Nurse Manager. We also have the checklist that we go through during orientation. With agency staff - as soon as

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they physically come into the building, they are checked in at the front desk. The receptionist will check in with them to make sure they are on the schedule. They show photo identification. Receptionist will have them read and sign the form onboarding checklist. From there, the staff check in with Scheduler. If the Scheduler is not here, there is a designee or Nurse Manager to check where they are going. Nurse Supervisor will escort the agency staff to the assigned unit and introduced to the other staff. Regarding V5, she came in 3 PM to 11 PM shift. She should have been checked in with V6 (Nurse Supervisor). He (V6) was the one who signed her onboarding checklist.

On 4/29/24 at 1:55pm V6, stated during interview, "Usually, the agency CNA checks in at the front desk. Then they go to their assigned floor. That time, she (V5) did not look for me or Scheduler, but I saw her at 2 West. I asked her (V5) and told her that she is assigned to 3 East and should go there; and get directions from her nurse, V4. I did not do any orientation/checklist on V5 at the time. V4 was the one who gave the orientation. I only ask about password and if there are any issues to call me."

On 4/29/24 at 2:20pm V4 was asked if she did an orientation on patients and policies with V5. V4 mentioned, "V5, that was my first time working with her. When she came, I did not do any orientation regarding patient care or policies. Patient care is discussed among CNAs during shift change. On my end, I don't do any policies orientation. Management does that."

Agency Nurse Onboarding Checklist showed V5 signed and dated the form 4/26/2026. The form was verified and signed by V6. V6 denied any

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knowledge on completing her (V5) onboard checklist. The date was marked wrong when it was signed.

V5's Agency Orientation Checklist also showed V5 signed the form with a wrong date as 4/26/2026. The form was completed by V6, which he (V6) also denied that he provided the orientation to V5. In this orientation checklist, items that should be provided by agency such as dementia care training, references, background check (to name a few) were not initialed. Facility orientation items that facility should complete such as Dementia training; abuse policy (to name a few) were also not initialed. V2 stated in an interview that all items should be initialed by the one providing the orientation.

On 04/30/24 at 12:48 PM, V10 (Special Care Unit Director) was interviewed regarding Dementia unit in the facility. V10 stated, "This is the Dementia Unit, third floor. All staff assigned here are certified Dementia trained. Agency staff are not trained because they don't work full time here. When they come to the floor to work for the shift, they will be oriented to look at the Kardex, plan of care, behavior monitor and interventions. They will be able to see the plan of care for each resident they were assigned to." V10 also stated in a follow up interview, "R1 is kind of stubborn and has his own way to do things. When we do care, we have to explain it to him more than five times. If not, he will not allow staff to touch him and he gets agitated. R2 does not have much behavior. During care, he becomes resistive, he will hold other staff hand. When he does that, we will give him sometimes, leave him alone for 5-10 minutes and come back."

On 05/01/24 at 10:16 AM, V15 (Staffing/Schedule

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Co-Ordinator) was asked regarding background checks on agency staffing in the facility. V15 replied, "We use agency staff for like 40% most of the time particularly evening and night shifts and on weekends. When they come to the facility, agency staff will check in at the front lobby and I will be directed to my Supervisor, V6, who will guide the assignment. For agency staff, I don't do the background check, it is the agency who does their own background checks. For new agency staff, I don't check the background or any paperwork because agency does that, and we trust the agency. I don't do any screening prior to agency staff working in the facility. We know for sure that the staff these agencies are giving are qualified to work. We trust the agency that their staff are screened prior to their shift."

On 05/01/24 at 11:03 AM, V2 also mentioned during interview, "For V5, I have to call agency Human Resource to verify background on or before shift starts. I have to receive those documentation. I received her (V5) papers last Friday 04/26/24 prior to start of shift." Facility presented V5's local state agency's health care worker registry paperwork. There were no other background or screening documentation on V5. V2 continued, "They wouldn't be in the agency if they are not eligible or appropriately screened. We rely on the agencies for their staff that we use with the background check that they conduct. Everybody is screened and checked out. Agency staffing abuse knowledge and training is automatic, someone who had been working in the healthcare setting should receive training on elder abuse. For us, once they (agency staff) physically come into the facility, they are orientated verbally by Nurse Supervisor or designated Nurse. We also provide them (staff agency) with a badge with abuse emergency. On the badge, it indicates

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who the abuse coordinator is and the types of abuse. For our regular staff, we do abuse training upon hire, new hire orientation, quarterly and as needed, if abuse is triggered. We also have online training annually. Agency staff are included if they are in the building working, they are invited to attend. When we do abuse training, we do it per shift, normally through verbal and giving of handouts. We like to do demonstration by creating a scene and ask them to identify abuse. We reiterate that any suspicion of abuse should be reported. We have an open door policy making sure that staff continue to work comfortably with residents and other staff. V4 and V7 (RN) are agency staff and have been working with us for quite a while now. Human Resources should have their papers."

V2 presented the following documents on V5 sent by agency electronically prior to start of her shift:
Passport
Local health agency healthcare worker registry
Pre-employment physical form
Tuberculosis skin test
CPR (Cardiopulmonary Resuscitation) card certificate
COVID (Coronavirus) vaccination card

On 04/30/24 at 11:37 AM, V8 (Medical Director) was interviewed regarding prevention of abuse in the facility. V8 replied, "Education and communication to make sure abuse would not happen again. I don't have any input on the hiring, I don't know how these staff are vetted. Nursing Supervisors need to be aware of what is going on. My role is dealing with medical issues. I can't speak to the requirements for this agency hiring. Nurses need to be educated, supervisors need to go over with nurses making sure they are comfortable in handling or dealing with this kind

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of population with Dementia. All patients should be protected. The fact that they have Dementia they need to be protected."

On 05/01/24 at 12:20 PM, V17 (Human Resources Director) was asked regarding background checks and personnel files of agency staff. V17 verbalized, "I don't keep the background checks and personnel files in a physical file. I saved it in the computer. For Agency staff, V15 takes care of the background checks, obtaining identification and COVID cards. She is the point person that gets the file, and she will just transfer it to me." Surveyor asked V17 to pull personnel files of V4 and V7. V4 and V7 are agency staff and are still working in the facility. During interviews, V4 stated she had been working in the facility for eight months now, while V7 is assigned to work in the facility multiple times. V17 stated, "V4 and V7 are agency staff. I don't see their background checks. I believe V15 has a binder that she keeps for all background checks. V5 is new, I don't have her files."

On 05/01/24 at 1:10 PM, after reviewing video footage provided by V2 from facility's camera, V5 arrived in the third floor Dementia Unit at 3:20 PM on 04/26/24. V5 went directly to the nurses' station where V13 (Agency CNA) showed her the schedule, went over the orientation binder. V5 was just seen flipping the pages of the binder, signed a form, then went directly to get her cart in the hallway. Video time stamped 3:20 PM to 3:26 PM showed it took six minutes for V5 to do all the necessary orientation she was provided before the start of her shift.

On 05/02/24 at 4:37 PM, surveyor was able to contact V5 after several attempts, however, V5 stated she already discussed everything related

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to the incident on 04/26/24 with the Supervisor and refused to talk further. She stated she is busy and at work.

On 05/06/24 at 1:59 PM, V3 (Director of Nursing) was asked regarding abuse and care of residents with Dementia in the facility. V3 mentioned, "We have guidelines, policies and procedures to follow regarding abuse. We do abuse in services on our staff upon hiring, orientation before they go to the unit. We do it annually, and as needed - when there is occurrence of abuse incident. For agency staff, expectation is they are being screened by the agency. When they come in here, we provide them with education about abuse, falls, like a general orientation. The orientation is given one on one with them by myself, Assistant Director of Nursing or Nurse Supervisors. The nurse on the floor provides education too. Our staff and the Supervisors are trained and aware of our guidelines when it comes to agency staff. And because the Supervisors would know the agency staff assignments, training in the care of demented residents would be included in their orientation. And floor nurses should also be educating the agency staff in the Dementia related care."

On 05/13/24 at 2:20 PM, V1 (Administrator) stated during interview, "Facility should be free from abuse. Whenever there is suspicion of abuse, residents should be safe, needs to be separated from staff if it is a staff abuse on resident or from resident if it is a resident to resident abuse. Staff has to follow abuse protocol to do what they are supposed to do. All agency staff background checks are done before they start to work and other documents were provided to facility. We need to verify that their background checks are done and prior to working here in the

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facility and that facility is provided with copies. Agency staffing should have 4-hour Dementia behavior training prior to work and if they don't have, then they will not be assigned to the Dementia care unit. Third floor is Dementia certified unit and staff should be trained regarding dementia.

Facility's policy: Abuse and Neglect, dated 07/14/23.
Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations.
Types of Abuse and Examples:
1. Physical: Physical abuse includes but not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, and roughly handling
2. Verbal: Verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing, yelling, threatening harm, trying to frighten the resident, racial slurs, etc.
7 Steps in Abuse Prevention:
This facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven federal components of prevention and investigation. The seven elements of prevention and investigation include:

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S9999	Continued From page 20 I. Screening: Have procedures to: Screen potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreating residents. This includes attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries. The facility will also not allow contracted or temporary staff from working in the facility if the contracted or temporary staff was found by the contracting agency to be with disqualifying findings from the registry if registry check is required for the contracted staff. Similarly, prior to placement in the facility, the facility will require background check of prospective consultants, contractors, volunteers, caregivers working on behalf of the facility, and students in its nurse aide training program and students from affiliated academic institutions including therapy, social, and activity programs to care for residents to be done either the facility itself, the third-party agency or academic institution. 1. Initiate a reference from the applicant's previous employer. 2. Obtain a copy of professional licenses. The facility will check annually to ensure professional licenses are current and not expired. 3. Check with the Illinois Nurse Aide Registry now known as Healthcare Worker Registry upon hire, to determine reports of abuse, neglect and theft if staff is not a licensed staff. 4. Initiate Illinois State Police fingerprint check for non-licensed applicants or new hires within 10 days of hiring, unless the applicant had been previously finger-printed in accordance to the Illinois Background Check Act. The Illinois State Police Web Portal will automatically update convictions of those previously fingerprinted. II. Training: Have procedures to: Train	S9999		

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employees, through orientation and on-going sessions on issues related to abuse prohibition, neglect, exploitation, misappropriation of property such as:
Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents.
Abuse identification and recognizing signs of abuse.
How staff should report their knowledge related to allegation without fear of reprisal.
How to recognize signs of burnout, frustration and stress that may lead to abuse; and to what constitutes abuse, neglect, exploitation, and misappropriation of resident property.
Understanding of behavior that has an increase risk of abuse.
III. Prevention: have procedures to:
Develop and implement policy on abuse, neglect, theft, exploitation, and misappropriation of property.
Deployment of sufficient and trained staff to deal with behaviors in the units.
The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their bed.
VII. Reporting/Response: Have procedures to:
If the event that results in allegation of abuse also causes the individual to suspect a crime, the facility will also report to the local law enforcement agency.

(B)