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 04/23/2024

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S 000	Initial Comments Investigation of Facility Reported Incident of 4/21/24/IL172218.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 300.3240 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) This requirement was not met as evidenced by: Based on interview and record review the facility failed to care for a resident in a way to prevent abuse. This applies to one of three residents (R1) reviewed for abuse in the sample of 6.	S9999		

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The findings include:

The facility care plan for R1 shows diagnoses to include vascular dementia, atrial fibrillation and hypertension. The brief interview for mental status (BIMS) assessment dated 3/28/24 shows R1 to have moderate cognitive impairment. The undated initial care plan for R1 shows she requires one to two assistance with a gait belt and walker for ambulation.

The facility reported incident dated 4/21/24 shows an allegation of verbal abuse by three Certified Nursing Assistants (CNA) was made against another CNA. This incident involved R1 and CNA V3. The report shows V3 yelling at R1 as she was being assisted to bed, telling R1, [You need to fu****g listen to me]. The report shows the three CNAs reporting this incident to the nurse on duty and V3 being suspended pending an investigation.

On 4/23/24 at 9:00 AM, R1 was observed dozing in a recliner in the resident lounge. R1 was not able to answer my questions regarding the staffs behavior.

On 4/23/24 at 9:30 AM, V4 Licensed Practical Nurse (LPN) and V5 Registered Nurse (RN) said R1 oriented to person only and can get resistive with care such as transfers and ambulation.

On 4/23/24 at 10:10 AM, V6 CNA said on Sunday night, 4/21/24 at around 9:30 PM, she was giving report to the next shift when she overheard screaming from R1's room and V3 CNA yelling [You need to fu****g listen to me]. V6 said they went into the room and R1 was on the bed and V3 was standing over her covering her up with

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the blankets. V6 said she made sure R1 was okay and went and told the nurse on duty what she had seen and heard.

On 4/23/24 at 1:55 PM, V9 CNA said she was giving report to the third shift staff in the hallway of the health care unit when she heard a scream from the R1's room. V9 said she heard V3 yell [You need to fu****g listen to me]. V9 said she checked in on R1 and R1 was lying in bed and V3 left the room. V9 said she immediately went to tell the nurse on duty what she had observed.

On 4/23/24 at 11:15 AM, V7 RN said she was the nurse on duty the night of 4/21/24 and at around 9:30 PM, V6, V9 and V11 all CNAs came to her and said they needed to report abuse. V7 said all three CNAs said the same thing, that they overheard V3 yell at R1 saying, [You need to fu****g listen to me]. V7 said just minutes prior to this V3 had come to the nursing station and said she was leaving and would never pick up a second shift assignment again and walked out of the building. V7 said she called the charge nurse to report the allegation, that V3 had left the building before the end of her shift and then had all three CNAs make a written statement of what they had observed.

On 4/23/24 at 3:15 PM, V10 LPN said he was the nurse in charge on 4/21/24 for the night shift. V10 said he got a call from V7 saying three CNAs heard V3 swearing at R1. V10 said he made sure V3 had left the building and then called the Director of Nursing (DON V2). V10 said V2 tried to call V3 to suspend her but V3 would not answer her phone. V10 said V2 told him to not allow V3 back into the building in the morning when she was supposed to return to work for the day shift. V10 said at 5:30 AM the next morning,

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he met V3 at the door and told her she was suspended from work for now and the administration staff would be contacting her later that morning. V10 said V3 left the facility without any comments.

On 4/23/24 at 3:30 PM, V11 LPN and Memory Care Director said when she arrived to work on 4/22/24 she was told by V10 that there had been an allegation of abuse made against V3 by three CNAs. V11 said an investigation had been started and she read the statements made by V6, V9 and V12, then went and talked to V7 RN about what had happened. V11 said she met with V1 Administrator and they called V3 for her statement. V3 denied all the allegations made against her. V11 said it was decided to terminate V3 due to the allegations by three other staff with the same allegations.

On 4/23/24 at 2:30 PM, V1 said she was told of the abuse allegation. V1 said she reviewed the written statements, spoke with the accused CNA, V3 and it was decided to terminate V3 for the abuse. V1 said it would never be allowed for any staff to speak to any resident in that way.

On 4/23/24 at 10:22 AM, V3 said she would never speak to a resident the way she has been accused of and denied all accusations against her.

V2 DON was not available for an interview as she was on vacation. V12 CNA did not return my phone call after a message was left for her.

The facility investigation into the incident shows written statements dated 4/21/24 from V6, V9 and V12 all CNAs. All three statements included hearing V3 say to R1, [You need to fu****g listen

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S9999	Continued From page 4 to me] coming from R1's room and when entering the room they saw V3 standing over R1 while R1 was lying in bed. The facility investigation also showed the CNAs reporting the incident to the nurse on duty, the on duty nurse reporting to the charge nurse and the charge nurse reporting to the DON. V3 left the facility after walking out early and being suspended the next morning when she returned to work the day shift. V3 was later terminated by the facility after the investigation was completed. The undated facility policy for abuse/neglect prevention shows all residents have the right to be free from abuse... (C)	S9999		