STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 11/21/2024

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S 000	Initial Comments Complaint Investigation: 2449425/IL181119	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240b) 300.3240c) 300.3240d) 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	S9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) 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 and to the Department. (Section 3-610(a) of the Act)

d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, 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 requirements are not met as evidenced by:

Based on interview and record review, the facility failed to report verbal abuse allegations to Illinois Department of Public Health, and the facility failed to investigate verbal abuse allegations for 1 of 3 residents (R2) reviewed for abuse. This failure resulted in R2 becoming upset, crying, refusing medications and refusing to eat.

Findings include:

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R2's Face Sheet which is undated documents that R2 was originally admitted to the facility on 3/14/11 with diagnosis of weakness, need for assistance with personal care, major depressive disorder, anxiety disorder, persistent mood disorder, borderline personality disorder, schizoaffective disorder, unspecified psychological disorder.

R2's Minimum Data Set (MDS) dated 10/22/2024 documented R2 is cognitively intact.

R2's Minimum Data Set (MDS) dated 10/22/2024 documented R2 is cognitively intact. R2's mood is often down with little pleasure in activities. She has impairment to bilateral upper extremities and uses a wheelchair for mobility. She requires touching assistance or verbal clues with eating.

R2's Care Plan dated 9/23/2024 documented problems that R2 can be socially isolative when she is in a bad mood. The goal is that she will increase social interaction with interventions that staff will encourage resident to spend more time in social activities.

On 11/20/2024 at 9:55 am, R2 stated she had gone to shock treatments (on 11/13/2024) and had come back to the facility feeling excited afterwards because she felt better by feeling more confident and feeling less prone to outbursts. At about 4:30 or 5:00 pm, R2 asked V9, Medical Records, if she could lie down and eat in her room because she was tired. V9 stated that she could. V4, Certified Nurse Assistant (CNA) then came into the room and yelled at me and stated that I could not eat in my room. R2 stated she told V4 that V9 had said she could. R2 stated that she then started crying and told V4 that this was abuse. V4 started looking at her and

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laughing at her. R2 stated that she (R2) used to buy V4 sodas, but she (V4) has always been hateful to me. R2 added that she doesn't get along with her. R2 stated that V4 began laughing at her and making fun of her. R2 stated that she was so upset and mad that she didn't eat supper. R2 stated that it really hurt her feelings. R2 added that V4 often tells her she can't eat in her room, causing her to start crying and refuse to eat if she must go to the dining room for her meal when she doesn't want to on that day. R2 stated that this makes her feel really bad. R2 stated that she told the next nurse on the night shift, and she said she would call V1, Administrator and V2, Director of Nurses (DON) and told me not to worry about it. R2 stated that V4 told one her friends in the facility that R2 had "lied on her." R2 is unable to remember which friend in the facility this was.

On 11/20/2024 at 10:35 am, V5, CNA stated that the day after the incident V5, was told by staff that R2 got in wheelchair and went up front and spoke with V2, Director of Nursing (DON). V5 stated that V2 did nothing and did not send V4 home. V5 stated V4 came in to work the day after the incident and would walk in the hall past R2's room antagonizing her and laughing at her. When V4 would walk past R2's room, R2 would yell out that that was the staff member who was mean to her. V5 stated that staff do not have the same assigned halls that they work on all halls. V5 worked with R2 the next day after the incident and stated that R2 wouldn't take her medications or get out of bed because she was still upset. V5 stated that she has seen and heard V4 talk to some residents roughly in the past but is unable to remember which residents this was. V5 overheard V4 tell a resident down the 400-hall loudly that she was not going to get the resident

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up and down up because that means she is doing double the work, and she don't get paid enough for that.

Facility Staffing sheets for November 14, 2024, documented that V4 was assigned for fifteen-minute checks on residents. Daily staffing sheets also documented V7 assigned to the 200-hall for the day and evening shifts on 11/14/24.

On 11/20/2024 at 1:30 pm V6, Receptionist, stated she was aware of the incident on 11/13/2024. The next day after this, on 11/14/2024, V6 stated that R2 was pushed in a wheelchair to the receptionist desk and V6 witnessed her pointing at V4 and yelling "that's her, that's her." V6 stated that R2 was very upset and crying hard. V6 stated that V2 was there talking with R2 also. V6's daily notebook was reviewed, and a page dated 11/14/2024 and line number four documented that "R2 was very upset about V4."

On 11/20/2024 at 2:50 pm, V7, Licensed Practical Nurse (LPN) stated she was working on 11/14/2024 and was assigned to the 200-hall. V7 stated that R2 was crying and wouldn't take her 11:00 medications. V7 stated R2 kept crying and wouldn't talk to me. V7 stated that R2 did get in a wheelchair and stated that R2 was being mean to me and yelling at me. Later that day, R2 would not take her medications. R2 would see V4 walk by and yell out "that's her, that's her. V7 stated that R2 said that she wanted to leave the facility and that she didn't feel safe. V7 stated that R2 received a one-time intramuscular (IM) injection for Zyprexa ordered because of her recent behaviors. V7 stated that she hadn't seen R2 exhibit this type of behavior in a long time. V7

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stated that this only occurs when someone makes her very upset. V7 also stated that she had worked the evening shift on 11/13/2024 and R2 was lying in her bed crying and repeating "it's over, it's over." V7 tried to console R2 and to ask her to talk about what was bothering her but R2 refused to talk with her about it. R2 stated that she didn't want to be here, she wanted to leave. R2 did take her evening medications that night.

On 11/20/2024, V2 stated via telephone that she was told that R2 had come back from her electroconvulsive therapy (ECT) treatment and went to the dining room. R2 then decided to go lie down. R2's tray had been delivered to the dining room and V4 told R2 she would have to go out in the dining room to eat. V2 said that she was then told that R2 refused her tray. V2 then asked other CNAs if they had ever refused to go get a tray or refused to bring it to a resident. An in-service was provided on customer service. V2 stated she was new to the DON position and had the guidance of V8, Regional Nurse Consultant. V2 stated that she didn't know anything about the events of 11/13/2024 until the next day, 11/14/024. Once she learned this, V2 stated that she assigned V4 to perform fifteen-minute checks on the 300 and 500 halls.

On 11/20 /2024 at 2:30 pm, V1, Administrator stated that V2 called her on 11/14/2024 to tell her about the allegation of customer service incident involving R2 and V4.

On 11/20/24 at 4:00 pm V10, transportation stated that R2 goes to ECT treatments the third Wednesday of every month. V10 stated that last Wednesday on 11/13/3024 that he and R2 left the facility around 8 am and returned about 11:30 am. He stated that R2 told him she felt great. V10

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added that "(R2) hadn't been that good in a long time."

On 11/20/204 at 4:35 pm, V4 stated via telephone that she had been notified by one of the staff that people "are there lying on me." V4 stated that on 11/13/2024 she worked the evening shift from 2:00 pm until 10:00 pm on the 200-hall. V4 stated that she had just left the dining room and came to help pass trays on the hall. V4 stated that she saw that R2 was in bed and went to V11, CNA who was assigned to R2 and told her that the nurses are wanting the residents to eat in the dining rooms. V4 stated that she told V11 that R2 was not going to eat. V4 stated that she never went back into R2's room. V4 stated that V11 verified with R2 that she was not going to eat supper that night.

On 11/21/2024 at 10:50 am V11, agency CNA stated that she was working on the 200-hall on 11/13/2024. She stated that the time was around 5:00 pm and when she walked out of another resident's room, V12, CNA, told her that R2 was ready for bed. V11 told R2 that she would go get some gloves and come right back. When V11 returned, R2 had already put herself to bed. V11 told her that dinner was ready. R2 stated that she was not going to go to dinner because she was tired from getting up so early for her treatment today. V11 stated that she offered to bring a tray to her, but R2 refused. R2 told her that she wanted to sleep. V11 then went to the dining room to help pass out trays. When she returned to the 200-hall, V4 told her that R2 was not happy and was having behaviors. When V11 went into the room, R2 was crying and told her that V4 was mean to her. R2 said that V4 had told her if she wanted to eat, she needed to get up and go down to the dining room. R2 stated that she was upset

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because V4 was mean to her. V11 offered to go get her tray but she said she didn't want to eat. V11 stated that shortly after telling her she didn't want to eat, R2 went to sleep.

On 11/20/2024 at 12:50 pm V1, Administrator, stated that she is the abuse coordinator. V1 was aware of an incident between R2 and V4 and stated that she was on vacation during that time. V1 stated that she did receive a phone call from V2 telling her about the situation. V1 stated that V2 had told her that R2 had reported that V4 was refusing to give her food and yelling at her. V4 told V2 that R2's meal tray was in the dining room, and she was going to get it for her. V2 had told her that she had interviewed the staff on the hall and the other residents who stated they hadn't heard anything. V1 was not told by V2 if V4 was sent home. The customer concern and feedback form were signed by V1 on 11/19/2024 since there were no findings reported and customer in-service regarding tray delivery had been performed.

On 11/20/2024 at 3:40 pm spoke with V8, Regional Nurse Consultant by phone. V8 remembered that V2 had called her regarding the incident between R2 and V4. V8 had been told this was a customer service issue and she recommended that V2 perform an in-service regarding customer service for meal trays. V8 stated that no allegations of abuse had been reported to her. V8 stated that if this had been reported as any type of abuse that the employee would be suspended until the investigation was complete.

There was no abuse investigation provided by the facility for R2 and V4.

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S9999	Continued From page 8 Abuse prevention program policy reviewed last on 9/2017 was reviewed. It stated that the facility desires to prevent abuse, neglect, exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. It stated that employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property is unsubstantiated. (B)	S9999		