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S 000	Initial Comments Facility Report Incident of 11/18/24/IL181590	S 000		
S9999	Final Observations Statement of Licensure Violation (1 of 2) 300.3240a) 300.3240b) 300.3240e) 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). 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). e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act). This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure a resident was free from abuse	S9999		

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by facility staff; failed to report verbal abuse in a timely manner; and failed to protect vulnerable residents from resident to resident abuse for 3 of 3 residents reviewed for abuse in the sample of 11.

The findings include:

1. The facility's Final Report for (abuse) allegation reported on 11/18/24 showed, "The CNA (Certified Nursing Assistant) against whom the original allegation was made, V6, denied making the statement that the dietary workers accused her of, but she admitted telling [R1] that if she keeps trying to bite her, she is going to put [R1's] hand up to her mouth and let her bite herself. [V6] said that she only made the statement because other CNAs said it. She named [V7, V8, V9, and V10]. All were removed from the schedule until completion of investigation. [V6's] employment was terminated due to the statement that she admitted to making to [R1]... Based on staff interviews, however, the administrator and DON (Director of Nursing) determined that have enough evidence to conclude that [V7 and V10] made similar statements to other staff that as a way to get [R1] to stop biting, tell [R1] that if she continues to try to bite, they're going to put her hand to her mouth to make her bite herself... we believe that based on statements they reportedly made to staff, there is a strong risk for verbal abuse and therefore we determined their employment would be terminated. This investigation cleared [V8 and V9] of any allegation of verbal abuse. As a result of the investigation, four staff members were discipline for failure to report concerning statements to the administrator and DON..."

R1's Facesheet dated 11/27/24 showed she was

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admitted 10/2/24 with diagnoses to include, but not limited to: dementia with behavioral disturbances, diabetes, hypertension, GERD (gastro-esophageal reflux disease), and bacterial pneumonia.

R1's Brief Interview for Mental Status (BIMS) Evaluation dated 10/7/24 showed she had severe cognitive impairment and was unable to complete the assessment.

R1's ADL (Activities of Daily Living) Only Evaluation dated 10/2/24 showed R1 was totally dependent on staff for bed mobility, transfers, toilet use, personal hygiene and dressing.

R1's Behaviors Care Plan initiated 10/4/24 showed interventions to include, but not limited to: "Staff will be patient and supportive." This care plan showed R1 had a history of harming self/others/property. It showed R1 was resistant to care and will often curse, hit/bite or throw things at those attempting to assist her. This care plan showed R1 required staff to manage behavior episodes. R1 was often physically aggressive and/or combative with staff. R1 also became restless. Staff will provide 1:1 care when resident becomes restless, combative, or aggressive.

R1's Psychiatry Initial Evaluation dated 10/23/24 showed, R1 had a history of dementia with behavioral disturbance. R1 was a poor historian and history was obtained from staff and chart review. This note showed, "Today she is seen wandering in the halls without her walker and has entered another patient's room and laid on the bed. Nurse and aide attempted to redirect her with diversionary measures and verbal cueing which were unsuccessful. She punched the nurse

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in the stomach and hit her several times. In addition, she was yelling out multiple profanities and disruptive. Nursing staff reported that she has daily behaviors with verbal outbursts, self transferring, poor safety awareness, biting, hitting and aggressive behaviors. Staff report that she is unable to be redirected most of the time. Quality described as chronic. Symptoms are steady. Worse with redirection. Nothing makes it better... Risk Assessment: Patient poses a risk to self and others due to aggressive behaviors, including punching and hitting staff. Poor safety awareness and self-transferring behaviors increase risk of falls. Daily behavioral issues, including verbal outbursts and inability to be redirected, present ongoing management challenges..."

On 11/27/24 at 8:57 AM, V5 (Dietary Aide) said on 11/18/24 she was finishing up her shift, walking through the healthcare center to get back to the kitchen. V5 said V4 (Dietary Aide) was walking with her. V5 said she saw R1 hitting V6 (CNA) and V6 told R1, "If you don't stop hitting me, I'll stick my finger down your throat." V5 said R1 was sitting in a recliner, near the nurses' station and V6 was seated in a chair next to R1. V5 said she didn't like the way V6 spoke to R1. V5 said she asked V4, "Did I really just hear that?" V5 said V4 said she heard the same thing, but they didn't know what to do. V5 said she went to the kitchen and spoke with her co-worker (V14 - Dietary Aide) and she told her report it to V2 (DON) right away. V5 said she'd never heard anything like that before. V5 said the residents should be treated like our family. V5 said R1 doesn't know what she is doing and deserved to be treated with patience. V5 said the staff should never threaten a resident like that.

On 12/3/24 at 8:00 AM, V4 (Dietary Aide) said on

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11/18/24 she was walking through the healthcenter with V5. V4 said R1 was seated in a recliner, near the nurses' station and V6 (CNA) was seated next to her. V4 said R1 was swinging at V6 (CNA) and V6 told R1, "If you hit me one more time, I'll shove your fingers down your throat." I asked V5, "Did you just hear that?" V4 said she told V14 (Dietary Aide) and they were told to report the incident to V2 (DON). V4 stated, "This was the first time I've had to report abuse. I was surprised to hear [V6] talk like that. I couldn't believe it."

On 11/27/24 at 1:51 PM, V14 (Dietary Aide) said she did not witness the incident on 11/18/24. V14 said her co-workers said they saw R1 hitting V6 (CNA) and reported that V6 told R1, "If you don't stop hitting me, I'll stick my finger down your throat." V14 stated, "I told them to report it right away because that's abuse. No resident deserves to be treated that way regardless of their behavior."

On 11/27/24 at 9:11 AM, V8 (CNA) said she was interviewed by management. V8 said she was disciplined for not reporting abuse to the administrator in a timely manner. V8 said the weekend of 11/16/24-11/17/24 she was working with V10 (CNA), R1 kept trying to get up out of her chair and V10 would shove her back down in the chair. V8 said R1 kept trying to stand and V10 kept shoving her down. V8 said R1 swung at V10 after she pushed her back down in the chair. V8 said she didn't report V10 to management that weekend. V8 said after the investigation V6, V7, and V10 (CNAs) were let go. V8 said V6 was always saying stuff to R1. V8 said V6 worked another job before she came to work at the facility and she seemed "snappy" with the residents. V8 said she'd heard V6 threaten R1 that she's put

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R1's fingers down her throat before. V8 said V6 just seemed irritated.

On 11/27/24 at 9:49 AM, V9 (Restorative CNA) said she was familiar with R1. V9 said R1 is confused, but can answer yes or no questions. V9 said R1 gets upset if she is asked too many questions. V9 said R1's face will get red, she grits her teeth, and will curse at the staff. V9 said sometimes R1's verbal aggression leads to physical aggression, but sometimes R1 goes straight to physical aggression. V9 said R1 is difficult to redirect and will hit, bite, and/or scratch at anyone near her.

On 11/27/24 at 10:12 PM, V11 (LPN - Licensed Practical Nurse) said she was working 11/18/24. V11 said that was a very chaotic day and R1 was having a lot of behaviors. V11 said she didn't hear anything but she was focused on what she was doing. V11 said the CNAs had been taking turns with R1 because she was being difficult. V11 said she never saw R1 pushed back down into the chair. V11 said she would expect any staff that witnessed that to report it. V11 said that could be abuse and there is a better way to keep R1 from getting up. V11 said staff shouldn't be threatening residents because that's a form of verbal abuse.

On 11/27/24 at 3:44 PM, V2 (DON - Director of Nursing) said R1 was admitted to the facility on 10/2/24, but the facility was not notified of any of R1's behaviors. V2 said R1 had agitated and aggressive behaviors since admission. V2 said V4 and V5 (Dietary Aides) came to her office between 1:30-2:00 PM on 11/18/24. V2 said they asked if it was ok for a CNA to tell a resident, "If you keep hitting me, I'm going to put my fingers down your throat." V2 stated, "I told them no, that's not okay. Who said it?" V2 said they

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reported V6 had said that to R1. V2 said she pulled V6 off the floor right away. V2 said V6 told her that she didn't say that. V2 said V6 told her she said, "If you keep biting me, I'll put your hand to your mouth, so you can bite yourself." V2 said V6 said she only said that because other CNAs had told her to say that to R1. V1 stated, "[V6] named other CNAs that had made that statement, so I started interviewing everyone working the healthcare center." V2 said the facility had terminated V6, V7 and V10 (CNAs) because staff interviews confirmed that they said, "If she tries to bite you, put your hand in front of her mouth and let her bite herself." V2 said she was not aware that V10 (CNA) had shoved R1 down in the chair. V2 said V8 (CNA) should have reported that to her immediately. V2 said V8 (CNA) was disciplined for not reporting abuse concerns in a timely manner. V2 said something happened the weekend before 11/18/24, but V8 didn't report it to management. V2 said the facility didn't find out until management was conducting the interviews for the abuse investigation. V2 said if R1 was "pushed or shoved" back in her chair, then that is physical abuse. V2 said threatening a resident is considered verbal abuse.

The facility's undated Abuse/Neglect Prevention Program Policy and Procedures showed, "All residents of [the facility] have the right to be free from abuse, neglect, mistreatment, corporal punishment, misappropriation of their personal property, exploitation and/or involuntary seclusion. Accordingly, [the facility] prohibits the abuse, neglect, mistreatment and corporal punishments of its residents and/or the misappropriation of their personal property. [The facility] has established these Policies and Procedures in an attempt to ensure the health and safety of all residents by preventing Abuse...

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S9999	Continued From page 7 These Policies and Procedures apply to all professional and non-professional employees of the facility, as well as to all residents, volunteers, family members, visitors, legal guardians or other individuals entering the facility. 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... to their direct supervisor and to the facility Administrator.... Definition: ..."Physical Abuse" - includes hitting, slapping, pinching, kicking, punching, and other forms of battery upon a resident. Physical abuse also includes controlling behavior through corporal punishment... Verbal abuse includes, but is not limited to, threats of harm and/or attempts to frighten the resident... Responsibility for Reporting Incidents: 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... Incidents and accidents include, but are not limited to, situations or allegations which, if true, could constitute abuse, neglect, exploitation, and/or Misappropriation of Resident Property... 7. Protection of Residents: The facility takes appropriate steps to protect its residents from further Abuse, Neglect, Exploitation and/or	S9999		

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Misappropriation of Resident Property. The following procedures are followed to protect residents from harm during an investigation: Residents who allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition will be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety as well as the safety of other residents and employees..."

2. The facility's Incident Investigation dated 11/1/24 showed at 3:30 PM, a CNA witnessed R1 hit R3 with a closed fist to his right arm. The investigation contained interview from V16 and V17 (CNAs). V16's statement showed R1 was attempting to get out of her wheelchair while refusing help. R3 was seated near R1. R1 hit R3 at least three times with a closed fist. After R1 was moved back, she scooted forward and proceeded to hit R3 more. As R1 was trying to get out her wheelchair, V16 attempted to help and redirect R1, but R1 hit V16 as well. V17's statement showed R1 hit V16 and R3. R1 hit R3 several times on the arm, similar to a punch.

R1's Facesheet dated 11/27/24 showed she was admitted 10/2/24 with diagnoses to include, but not limited to: dementia with behavioral disturbances, diabetes, hypertension, GERD (gastro-esophageal reflux disease), and bacterial pneumonia.

R1's Brief Interview for Mental Status (BIMS) Evaluation dated 10/7/24 showed she had severe cognitive impairment and was unable to complete the assessment.

R1's ADL (Activities of Daily Living) Only

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Evaluation dated 10/2/24 showed R1 was totally dependent on staff for bed mobility, transfers, toilet use, personal hygiene and dressing.

R1's Behaviors Care Plan initiated 10/4/24 showed interventions to include, but not limited to: "Staff will be patient and supportive." This care plan showed R1 had a history of harming self/others/property. It showed R1 was resistant to care and will often curse, hit/bite or throw things at those attempting to assist her. This care plan showed R1 required staff to manage behavior episodes. R1 was often physically aggressive and/or combative with staff. R1 also became restless. Staff will provide 1:1 care when resident becomes restless, combative, or aggressive.

R1's Psychiatry Initial Evaluation dated 10/23/24 showed, R1 had a history of dementia with behavioral disturbance. R1 was a poor historian and history was obtained from staff and chart review. This note showed, "Today she is seen wandering in the halls without her walker and has entered another patient's room and laid on the bed. Nurse and aide attempted to redirect her with diversionary measures and verbal cueing which were unsuccessful. She punched the nurse in the stomach and hit her several times. In addition, she was yelling out multiple profanities and disruptive. Nursing staff reported that she has daily behaviors with verbal outbursts, self transferring, poor safety awareness, biting, hitting and aggressive behaviors. Staff report that she is unable to be redirected most of the time. Quality described as chronic. Symptoms are steady. Worse with redirection. Nothing makes it better... Risk Assessment: Patient poses a risk to self and others due to aggressive behaviors, including punching and hitting staff. Poor safety awareness

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and self-transferring behaviors increase risk of falls. Daily behavioral issues, including verbal outbursts and inability to be redirected, present ongoing management challenges..."

R1's Behavior Note dated 11/1/24 showed R1 was in the recliner until 3:30 PM, then R1 got up in her wheelchair. R1 was was receiving one on one care from the CNA. The CNA witnessed R1 hit another peer resident (R3) with a closed fist to his right arm.

On 11/27/24 at 9:49 AM, V9 (Restorative CNA) said she was familiar with R1. V9 said R1 is confused, but can answer yes or no questions. V9 said R1 gets upset if she is asked too many questions. V9 said R1's face will get red, she grits her teeth, and will curse at the staff. V9 said sometimes R1's verbal aggression leads to physical aggression, but sometimes R1 goes straight to physical aggression. V9 said R1 is difficult to redirect and will hit, bite, and/or scratch at anyone near her.

On 11/27/24 at 2:30 PM, V17 (CNA) said she was working 11/1/24. V17 said after supper the staff were in the process of toileting residents and moving them to the living room area, near the nurses' station. V17 said R1 and R3 were seated near each other in their wheelchairs. V17 said R1 had been agitated the entire shift. V17 said V16 (CNA) was trying to move R1's wheelchair to create more distance between R1 and R3, but R1 used her feet to move her wheelchair toward R3. V17 said R1 leaned forward and hit R3 several times on his right arm and possibly his shoulder. V17 said R1 lashes out at anyone that she can reach and she is cussing most of the time.

On 11/27/24 at 3:44 PM, V2 (DON - Director of

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Nursing) said R1 was admitted to the facility on 10/2/24, but the facility was not notified of any of R1's behaviors. V2 said R1 had agitated and aggressive behaviors since admission. V2 said R1 did hit R3, it was witnessed by V16 and V17. V2 stated, "You saw the reports. She lashes out at anyone. It seems like she means to hit people. She's definitely swinging at them." V2 said R3 should have the expectation of safety at the facility and he should not have to worry about being hit by another resident.

3. The facility's Incident Investigation dated 11/26/24 showed at 1:45 PM R1 was sitting in a recliner and reached over to hit R2 (seated in a recliner next to her) in her arm twice. R2 was immediately removed away from R1. The facility's investigation contained written statements from V17, V18, and V19 (CNAs). V17's statement showed at the beginning of second shift, she was near the nurses' station/living room area when the entire PM shift witnessed R1 reached over and hit R2 several times, unprovoked on her left arm. R2 stated, "I'm being abused," and was almost in tears. About 10 minutes after the episode, R2 was asked if she was okay and R2 replied, "I feel okay, if she would just stop hitting everybody" and "that's enough of that." V18's written statement showed R1 was agitated. R1 leaned over the arm of her recliner, toward R2 and hit her twice on the arm. R2 leaned away, grabbing her arm, saying, "I'm being abused." V19's written statement showed R1 was seated in the recliner, next to R2. R1 leaned over the arm of her chair, made a fist, and punched R2. R2 grabbed her arm and stated, "I'm being abused." R2 was removed from the living room area. R2 stated, "She won't let me sit there." R1 continued to cuss and hit the chair.

R1's Facesheet dated 11/27/24 showed she was

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PARKVIEW HOME - FREEPORT	1234 SOUTH PARK BOULEVARD FREEPORT, IL 61032

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admitted 10/2/24 with diagnoses to include, but not limited to: dementia with behavioral disturbances, diabetes, hypertension, GERD (gastro-esophageal reflux disease), and bacterial pneumonia.

R1's Brief Interview for Mental Status (BIMS) Evaluation dated 10/7/24 showed she had severe cognitive impairment and was unable to complete the assessment.

R1's ADL (Activities of Daily Living) Only Evaluation dated 10/2/24 showed R1 was totally dependent on staff for bed mobility, transfers, toilet use, personal hygiene and dressing.

R1's Behaviors Care Plan initiated 10/4/24 showed interventions to include, but not limited to: "Staff will be patient and supportive." This care plan showed R1 had a history of harming self/others/property. It showed R1 was resistant to care and will often curse, hit/bite or throw things at those attempting to assist her. This care plan showed R1 required staff to manage behavior episodes. R1 was often physically aggressive and/or combative with staff. R1 also became restless. Staff will provide 1:1 care when resident becomes restless, combative, or aggressive.

R1's Psychiatry Initial Evaluation dated 10/23/24 showed, R1 had a history of dementia with behavioral disturbance. R1 was a poor historian and history was obtained from staff and chart review. This note showed, "Today she is seen wandering in the halls without her walker and has entered another patient's room and laid on the bed. Nurse and aide attempted to redirect her with diversionary measures and verbal cueing which were unsuccessful. She punched the nurse

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in the stomach and hit her several times. In addition, she was yelling out multiple profanities and disruptive. Nursing staff reported that she has daily behaviors with verbal outbursts, self transferring, poor safety awareness, biting, hitting and aggressive behaviors. Staff report that she is unable to be redirected most of the time. Quality described as chronic. Symptoms are steady. Worse with redirection. Nothing makes it better... Risk Assessment: Patient poses a risk to self and others due to aggressive behaviors, including punching and hitting staff. Poor safety awareness and self-transferring behaviors increase risk of falls. Daily behavioral issues, including verbal outbursts and inability to be redirected, present ongoing management challenges..."

R1's Behavior Note dated 11/26/24 showed, "Resident Sitting in the recliner in HC (healthcare center) lounge and (R2 was) sitting next to her in a recliner. [V19-CNA] was standing by the desk next to the elevator and observed (R1) hit (R2) on the arm. (R2) verbalized, "I feel like I've been abused." [V19 -CNA] assisted R2 to a wheelchair and brought her to the nurses' station. (R2) was tearful and verbalized, "She pounded me."

R1's Physician's Order Sheet showed on 11/26/24 there was an order to send to ER (emergency room) for evaluation of increased behaviors.

On 11/27/24 at 2:20 PM, V19 (CNA) said on 11/26/24 at the beginning of second shift, R1 and R2 were sitting next to each other. R1 made a fist, leaned over the arm of her recliner and hit R2's arm. R2 was sleeping, she woke up, grabbed her arm, and stated, "I'm being abused." R2 didn't do anything to R1, she was sleeping.

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On 11/27/24 at 2:30 PM, V17 (CNA) said on 11/26/24 she had just set her belongings down. V17 said R1 was seated in the 1st recliner and R2 was seated to R1's right. R1 was already upset, agitated, and cussing. V17 said R1 started swinging her arm in R2's direction, but a call light came on and she turned to answer it. V17 said the other CNAs were at the nurses' station and she alerted them. V17 said R1 reached over the arm of the recliner and hit R2 on her left arm. R2 was sleeping and woke up stunned. R2 looked like she was going to cry. We moved R2 out of the living room. Another CNA asked R2 if she was okay and she said, "I'd be ok if she'd just stop hitting everybody. That's enough or that has got to stop." V17 said R1 lashes out at anyone that she can reach and she is cussing most of the time.

On 11/27/24 at 2:45 PM, V18 (CNA) said on 11/26/24 at the start of shift. R1 was seated next to R2 in the recliners by the nurses' station. V18 said R1 leaned toward R2 and hit her left arm. R2 grabbed her arm and leaned away, saying, "I'm being abused." V18 said R1 ended up getting sent to the hospital.

On 11/27/24 at 3:44 PM, V2 (DON - Director of Nursing) said R1 was admitted to the facility on 10/2/24, but the facility was not notified of any of R1's behaviors. V2 said R1 had agitated and aggressive behaviors since admission. V2 said R1 did hit R2, it was witnessed by V17, V18, and V19. V2 stated, "You saw the reports. She lashes out at anyone. It seems like she means to hit people. She's definitely swinging at them." V2 said R2 should have the expectation of safety at the facility and should not have to worry about being hit by another resident.

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S9999	Continued From page 15 (B) Statement of Licensure Violation (2 of 2) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act). f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to completed criminal history background checks prior to admission and failed to completed department of corrections and sex offender website searches for 3 of 10 residents (R2, R6, R8) reviewed for criminal history background	S9999		

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checks in the sample of 11.

The findings include:

R2's Facesheet dated 11/27/24 showed she was admitted to the facility on 5/17/24. R2's Illinois State Police Criminal History Report was dated 11/27/24 (6 months after R2's admission date). The facility did not provide an Illinois Department of Corrections search for R2.

R6's Facesheet dated 12/3/24 showed she was admitted to the facility on 8/9/24. The facility did not provide an Illinois Department of Corrections search for R6.

R8's Facesheet dated 12/3/24 showed he was admitted to the facility on 10/26/24. The facility did not provide a Sex Offender website search for R8.

On 11/27/24 at 3:05 PM, V21 (Receptionist) said she is responsible for completing the resident criminal background checks. V21 said the Criminal History Background Check, Department or Corrections website search, and the Sex Offender website search should be completed on all residents prior to admission. The surveyor asked V21 why some of the website searches were missing. V21 replied, "I gave you everything I have. Those residents may have been before I was here. I keep a folder (with the time stamped printouts) for the ones I've done. I provided you what I could find. I don't know why all the searches aren't there." V21 said the purpose of criminal history background checks were to ensure safety for all the resident's at the facility.

The facility's undated Abuse/Neglect Prevention Program Policy and Procedures showed, "All

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S9999	Continued From page 17 residents of [the facility] have the right to be free from abuse, neglect, mistreatment, corporal punishment, misappropriation of their personal property, exploitation and/or involuntary seclusion. Accordingly, [the facility] prohibits the abuse, neglect, mistreatment and corporal punishments of its residents and/or the misappropriation of their personal property. [The facility] has established these Policies and Procedures in an attempt to ensure the health and safety of all residents by preventing Abuse... These Policies and Procedures apply to all professional and non-professional employees of the facility, as well as to all residents, volunteers, family members, visitors, legal guardians or other individuals entering the facility. 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... to their direct supervisor and to the facility Administrator.... Procedures and Preventions: ...3. Resident Screening: [The facility] shall request a criminal history background check on all new residents within 24 hours after admission. The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender..." (C)	S9999		