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	IL6007090	A. BUILDING: _____ B. WING _____	C 12/18/2024

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S 000	Initial Comments Complaint Investigation 24610127/IL182402	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3210t) 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 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on observation, interview and record review the facility failed to protect one (R9) resident's right to be free from mental abuse by a staff member (V1) and failed to protect a resident's right to be free from restricted access from areas of the facility without clinical justification. This failure resulted in R9 being yelled at and threatened by staff, crying, expressing humiliation, fear of participating in activities and threats of room move to a locked down Dementia unit if R9 walked the length of her own hallway.

Findings include:

The facility policy titled Abuse Policy revised 1/9/24 documents the Administrator and/or designee is the Abuse Coordinator for this facility. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment. It is the responsibility of all facility staff to ensure that all residents remain to be free from abuse,

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including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff's responsibility to report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). The facility will report all allegations of abuse timely to the proper authorities to include State Agency, Ombudsman, Power of Attorney (POA) and Physician ... Unreasonable confinement or Involuntary Seclusion means the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

R9's undated Face Sheet documents medical diagnoses as Cerebral Infarction, Peripheral Vascular Disease, History of Right Artificial Hip Joint, Seizures, Intellectual Disabilities, Alzheimer's Disease, Psychosis, Pulmonary Hypertension, Intervertebral Disc Degeneration, and Congestive Heart Failure.

R9's Minimum Data Set (MDS) dated 12/2/24 documents R9 as cognitively intact and uses a walker for ambulation.

On 12/12/24 at 9:35 AM, V16, Certified Nursing Assistant (CNA) stated "(R9) can only walk to the nurse's station and not any farther per (V1). I am not sure why but (R9) never walks down the rest of the hall. (R9) walks all around the halls but not

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down the other half of her own hall."

On 12/12/24 at 10:35 AM, V2, Director of Nurses (DON), stated V1, Administrator, asked V2 to be present for a conversation with R9. V2 stated V4, Social Service Director (SSD), was also present. V2 stated V1 did raise her voice at R9. V2 stated V1 was not cursing or screaming at R9. V2 stated R9 looked upset while V1 was raising her voice at R9. V2 stated a family member of another resident (R14) complained that R9 would walk by R14's room and stare in. V2 stated "Sometimes you have to be stern with these residents. You have to set firm boundaries. (V1) said to (R9) "I don't want to have to put you back on the Dementia unit. Do you like your freedom?"" V2 stated (R9) replied yes and was upset. V2 stated "(R9) cries all the time when she gets in trouble, so I don't know if she was crying that day. (R9) could have been crying. I don't really remember because (R9) is so sensitive she cries a lot anyway."

On 12/12/24 at 10:45 AM, V4, Social Service Director (SSD), stated on 12/6/24 at lunch time, V1 asked V2 and V4 to witness a conversation with R9. V4 stated V23, Director of Business Development, was already sitting in the conference room working for the day. V4 stated V1 yelled at R9 until she cried. V4 stated V4 could see R9 become visibly upset when V1 was yelling at her. V1 asked R9 if she wanted to live in the Dementia unit again and R9 replied "No! I hated it back there!" V1 then told R9 "You better get your act together or you will be moving back to the Dementia unit." V4 stated after this incident was over R9 walked back to her room with V4. V4 stated once R9 got to her room, she began sobbing saying "Why does (V1) talk so mean to me? (V1) yelled at me about walking down my

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own hallway. I won't ever walk down that part of the hall again!"

On 12/12/24 at 10:50 AM, V45, Anonymous, stated V1 yells at residents. V45 stated V1 has a loud voice naturally but the yelling is not meant for residents due to hearing impairment, V1 just yells at everyone. V45 stated V1 will slam her fist down on a table, yell from her office out into the hallway or just yell down the hall at staff in front of residents. V45 stated "I heard (V1) yelling at (R9) the day (12/6/24) (V1) brought (R9) into the conference room. I heard (R9) crying outside the conference room door when it was done. (V1) was yelling so loud you could hear her in the dining room down the hall. The residents in the dining room were looking around like "who is yelling like that?""

On 12/12/24 at 1:00 PM, V1, Administrator, stated V1 told R9 to not walk down the back half of R9's hallway due to a complaint that R9 was standing in the hallway staring in (R14's) room. V1 stated "I absolutely told (R9) to not walk down her hallway. (R9) could go to the nurse's station but no further. What am I supposed to do when there is a family member complaining about (R9) staring in (R14's) doorway? (V55) (R14's) Power of Attorney (POA) is just going to keep complaining so I made it clear to (R9) she can't go down there anymore."

On 12/12/24 at 1:10 PM, R9 stated V1 had come to R9 and told R9 that she was not supposed to walk past the nurse's station on her own hallway due to R14's wife complained that R9 was staring into R14's room. R9 stated R9 didn't think anything of that so she continued to walk all around the facility including past R14's room. R9 stated R9 might have stopped in front of R14's

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room but did not recall staring in at anyone, just admiring the room. R9 stated R14's room has a private bathroom and more space than her room and would like to move into R14's room. R9 stated "(V1) called me into that room by (V1's) office (conference room) to yell at me. (V1) yelled so loud everyone could hear it. (V1) did not use any curse language. (V1) was yelling at me because I walked down my own hallway. (R14) lives on my hallway too. I don't mean to bother (R14), I just like his room. (V1) threatened to move me back to the Dementia unit. I lived there once before, and it was awful. You are locked up back there. (V1) told me if I don't behave, she was sending me back there. I don't know why (V1) had to yell at me in front of all those people. That was humiliating. I remember crying in that room and I was very upset. I went back to my room and had a good cry. (V4) was there with me. (V4) was very kind and helped me calm down. I am never going down that hall again! I don't ever want to be treated like that again!"

On 12/13/24 at 12:45 PM, V23 Registered Nurse (RN), stated R9 walks from the nurse's station on South Hall where R9 resides, past her room, past the front offices, down North Hall and the back hall and then turns around when R9 reaches the other end of South Hall. V23 stated R9 will not walk by R14's room. V23 stated R9 has followed that same path every time for the last few weeks.

On 12/13/14 at 1:20 PM, R9 walked the entire length of North Hall in the facility, rounded the corner to walk the length of the back hall and then turned around when she reached the end of the South Hall where R14 resides. R9 then retraced her steps down the back hall and back down the North Hall. R9 stated "I can't go down there, or I will get into trouble with that mean lady

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Administrator (V1). I don't want to get yelled at anymore."

On 12/13/24 at 3:00 PM, V28, Registered Nurse (RN), stated R9 used to attend activities all of the time and has recently stopped going. V28 stated V28 has encouraged R9 to participate in activities but R9 declines stating she doesn't want to get into trouble.

On 12/13/24 at 3:15 PM, V27 stated V27 was walking in the hallway adjacent to the conference room '30 feet' away. V27 stated V27 heard V1 yelling inside the conference room. V27 stated V27 did not know until later that a resident (R9) was in the conference room with V1, V2 , V4 and V23.

On 12/18/24 at 1:52 PM, V43, Medical Director, stated V43 is very familiar with R9. V43 stated R9 walks up and speaks to V43 every time he visits the facility. V43 stated R9 has a fragile demeanor due to her Intellectual Disability and Mental Health history. V43 stated R9 should be walking around the entire perimeter of the facility in order to maintain her current mobility. V43 stated R9 had a Right total hip replacement in May 2024, and it is imperative to her recovery. V43 stated there is no reason why R9 cannot walk down the length of her own hallway and every hallway in the facility. V43 stated "I am not sure why the facility thought restricting (R9's) access to open areas would help resolve the issue. The last I checked, this is a free country. (R9) has every right to all of the resident designated areas in that facility. If you restrict that access, you are basically secluding the resident. We should never do that unless it's in case of an emergency." V43 stated staff should never raise their voices when talking to residents. V43 stated

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S9999	Continued From page 7 "Verbal and Mental abuse is a very serious issue. (V1) should have addressed the issue of where (R9) can walk or not in a better way. (V1) should never have raised her voice at (R9). There is no need to use a firm tone with (R9) or any other resident. (R9) will not respond to that. (R9's) temperament can be fragile and the facility staff should be trained on how to address issues without abusing residents." (B)	S9999		