STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	C 01/21/2025

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S 000	Initial Comments Complaint Investigation 2540346/IL184388	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.3240d) 300.3240g) 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 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.	S9999		

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g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These requirements were not met as evidence by:

Based on interview and record review, the Facility failed to thoroughly investigate allegations of abuse and submit their final abuse investigations for 3 of 3 residents (R1, R2 and R3) reviewed for abuse investigations. This has the potential to affect all 72 residents living in the Facility.

Findings include:

1. R1's Facesheet for 1/2025 documents a diagnosis of Parkinson's disease without dyskinesia, with fluctuations; Encephalopathy, unspecified; Type 2 diabetes mellitus with unspecified complications; Morbid (severe) obesity due to excess calories; Acute and chronic respiratory failure with hypoxia; Dysphagia following cerebral infarction; Other lack of coordination; weakness; anemia; Other lack of coordination; Atherosclerotic heart disease of native coronary artery without angina pectoris; altered mental status; Paranoid schizophrenia; Long term (current) use of anticoagulants; Essential (primary) hypertension; and Developmental disorder of scholastic skills, Unspecified.

R1's Minimum Data Set (MDS) document R1 was cognitively intact for decision making.

R1's Care Plan: with a start date of 12/11/2024 documents, "Problem: ABUSE/NEGLECT: (R1) is at risk for abuse and neglect related to

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schizophrenia DX (diagnosis of), Impaired mobility, requires assistance with all ADL's (activities of daily living)."

R1's Initial Report dated 12/11/2024 document, victim, wheelchair, mechanical lift, interviewable, no to informed decisions and alert and orientated x 2 and capable of communication. Resident reported a verbal abuse allegation. The person accused was immediately suspended. The concluding report to follow. The person submitting the report was documented as V1, Administrator. The report does not document the name of the staff.

On 1/15/2025 at 9:51 AM, R1 stated he does not remember any staff yelling at him and/or mistreating him and he does not want to get anyone in trouble.

On 1/15/2025 at 3:30 PM, V5, Family Member, stated, "I vaguely remember back in December there was a staff member that allegedly was verbally abusive to (R1) but honestly (R1) gets impatient so fast and when he wants something he wants it that second and gets upset if he does not get it. I don't remember the staff name and or anything else about it. I could not tell you If there was an investigation. I try and visit as often as I can, and I have not seen anyone mistreat (R1). I can only hope staff treat him good even when I am not around."

On 1/15/2025 at 1:33 PM, V1, Administrator, stated she did not have any final abuse investigation reports for R1, and she had provided everything she had.

No staff name, no verification of timecards that staff member was sent home, no interviews from

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other staff working that day, no interviews from other residents and no name of the alleged staff member was provided for R1.

2. R2's Facesheet for December 2024 documents a diagnosis of Type 2 diabetes mellitus with ketoacidosis without coma; Suicidal ideations; Metabolic encephalopathy; Essential (primary) hypertension; Hemiplegia, unspecified affecting right dominant side; Aphasia following cerebral infarction; Schizophrenia, unspecified; Bipolar disorder, unspecified; Dysphagia following cerebral infarction; Major depressive disorder, recurrent, unspecified; Cerebral infarction, unspecified; Cerebrovascular disease, unspecified; and Vascular dementia, unspecified severity, with other behavioral disturbance.

R2's Initial Report Incident date 12/10/2024, alleged abuse, victim (R2) wheelchair, not interviewable, alert and orientated x 1, but capable of communication. Initial report for abuse allegation at (Facility). It was reported that a staff member pulled resident by his feet into his room. The investigation was initiated as soon as the allegation was reported." (The allegation does document the name of the staff member). V1 was documented as the name of the person submitting the report.

On 1/15/2025 at 12:47 PM, V1, Administrator, stated there were no abuse reportable when she arrived at the facility. She only has what she started while she was here in the facility. No final investigations were completed for (R1), (R2) or (R3). There are no folders and/or interviews, only the initial reports is all she has.

R2's Progress Notes do not document any allegations of abuse.

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R2 was no longer in the facility and had expired on 1/1/2025 from Cardiopulmonary Arrest.

On 1/16/2025 at 3:32 PM, V1 stated she was still looking for the actual allegation and interviews that she had had regarding the allegation. (R3) had made the allegations and told staff he had seen (R2) being pulled by the legs. (R2) likes to throw himself on the floor and had behaviors of throwing himself on the floor. I remember interviewing people, but I do not know where those interviews are at, and I did do a final, but I cannot find my final report. I remember going back and looking at the cameras and I did not see anyone kick (R2) and staff transferred him with a sheet. I remember it was not substantiated. I am putting out so many fires here that I did not submit the final reports because of everything else that I am doing."

On 1/16/2025 at 4:33 PM, R3 stated, "(R2) had some issues and he would have the habit of throwing himself on the floor and yelling out. It got to the point where staff would check him one time and then be done with him. Now mind you, he was usually dressed in a hospital gown, and this is winter, and the ground is cold, and he would lay there for hours. I thought it was disrespectful and not right, but what really bothered me was one night I was at the nurse's station and the two nurses went into his room and as I was walking back to my room, they grabbed (R2) by his legs and pulled him into his room. For me that crossed a line, and I reported it to (V1). She came into my room and thanked me for reporting it and that was the end of it, and I never heard anything else. I never saw anyone kick (R2) but I felt like he was neglected and abused especially when staff would ignore him because they had went to his

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room earlier and so they would not go again."

On 1/16/2025 at 4:28 PM, No folder or interviews from other residents and/or staff were provided related to the allegation of abuse for R2 on 12/10/2024. No name of the staff member was documented. No interviews from other residents and or staff member and no timecards were provided documenting any alleged staff member was sent home. No final investigation with details of the alleged abuse was provided. No other staff member was able to confirm and or deny the incident.

3. R3's POS for January 2025 documents a diagnosis of Polyneuropathy, unspecified; Type 2 diabetes mellitus without complications; Pneumonitis due to inhalation of food and vomit; Radiculopathy, lumbar region; Other spondylosis, cervical region; Essential (primary) hypertension; Lumbago with sciatica, left side; Lumbago with sciatica, right side; Obstructive sleep apnea (adult) (pediatric); Hyperlipidemia, unspecified.

R3's MDS dated 12/14/2024 documents R3 was cognitively intact for decision making of activities of daily living.

R3's Care Plan: Problem: I was involved in alleged abuse related to a physical incident that occurred between myself and an employee of the facility. Date 7/25/2024.

R3's Incident Report with date of incident on 12/10/2024 document, (R3) male, wheelchair, interviewable, informed decisions, alert and orientated x 3, and capable of communication. Notification of an initial verbal abuse allegation at (Facility). The staff member accused of the allegation has been suspended pending an

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investigation. The final report will be submitted upon completion. This form was completed by V1.

On 1/15/2025 at 12:50 PM, V4, State Public Service Administrator, stated there was no final report provided from the facility for (R1, R2 or R3). There was an initial report for all of them, but no final report was submitted. In fact, there were no final reports from any abuse allegation the facility has sent into the state for December 2024 to present.

On 1/17/2025 at 4:00 PM, No other interviews, no details of any investigation was provided for R1, R2 or R3. No staff interviews, resident interviews and or anything related to any of the investigation for R1, R2 and R3 was provided

The Facility undated Abuse Policy documents, "All incidents of alleged abuse will be documented. Any incident or allegation involving abuse, neglect or misappropriation will result in an investigation. The Final. investigation report shall contain the following: Name, age, diagnosis, and mental status if the resident allegedly abuses or neglected. Facts determined during the investigation; conclusions of investigation based on known facts. Within five working days after the initial of the occurrence the final report will be sent to the Department of Public Health."

The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 1/16/25 documents there are 72 residents living in the Facility.

(C)

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300.1210d)6)
300.2210b)1)2)
300.2220a)1)2)
300.2630a)

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.2210 Maintenance

b) Each facility shall:

1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards.

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

Section 300.2220 Housekeeping

a) Every facility shall have an effective plan for

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housekeeping including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall:

1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements, and storage areas.

2) Keep floors clean, as nonslip as possible, and free from tripping hazards including throw or scatter rugs.

Section 300.2630 Sewage Disposal

a) All sewage and liquid wastes shall be discharged into a public sewage system when available.

These requirements were not met as evidence by:

Based on observation, interview, and record review, the Facility failed to ensure the plumbing and equipment was in safe, working condition. This has the potential to affect all 72 residents living in the Facility.

Findings include:

On 1/15/2025 at 10:42 AM, V1, Administrator stated the plumbers had just been here last week, but the basement was dry and she was not aware that there was any water leaking in the basement.

On 1/15/2025 at 10:39 AM, Tour of the basement was conducted and near the second crawl space (old maintenance room) the room was empty and did not contain any furniture. The space/tunnel crawl above the main structure, there was a hole in the floor with the sump pump running. The water was not coming from the sump pump.

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There was water all over the entire floor that was coming out of the room and flowing into the next adjacent room where there were lots of cardboard boxes with contents inside being used for storage. The water was not gushing but was gently flowing. The water was clear in color and was hot/warm water. When walking straight upon entering before getting to the old maintenance room there was a metal storage cabinet and against the wall were multiple boxes of supplies. The water was under the supply cabinet and underneath the supply's boxes. There were two fans running in two of the three rooms. The water was coming from the crawl space/tunnel and was not visible without assessing a ladder to see inside the hole.

On 1/15/2205 at 10:52 AM, R11 stated, "We are constantly having plumbing issues in this building, it is ridiculous! They are constantly shutting the water off, repairing something and then something else breaks and it starts all over. We even had sewer water in my room. It was disgusting! I am not exaggerating; this has been going on for about a month. Shutting the water off is an inconvenience and it is happening too much, I don't know how it is not fixed by now."

On 1/15/2025 at 10:58 AM, R31 stated the building has been having plumbing issues for months now and the pipes are always breaking.

On 1/15/2025 at 11:03 AM, R3 stated, the facility has been experiencing issues with the plumbing for months now and are constantly turning off the water to repair things. I think they need to replace the entire system because when they fix one another one breaks. It has been continuous."

On 1/16/2025 at 4:03 PM, V22, Plumber, stated,

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"It is difficult at this point to say how extensive the work will be and/or what needs to be done because we must cut out all the cast iron pipes that are in this small crawl space to gain assess to see what is actually going on. I am not sure if there is another crawl space, or another access, but unless we can find another way to get in it is going to be tough to even see what is going on. Right now, there is water coming from that area I believe it is a pin hole break in the pipe that is causing the water. We really will not know more until we get down there and see what is happening. This is an old building, with thin pipes and we will see what we need to do to try and fix it."

Resident Council Meeting Minutes dated 11/5/2024, documents, "Maintenance: Bathroom leaking."

Resident Council Meeting Minutes dated 12/3/2024 "Maintenance: Pipes broken."

On 1/15/2025 at 10:00 AM, Equipment and Maintenance Policy was requested to V1.

On 1/21/2025 at 10:00 AM, no equipment and or Maintenance Policy was provided.

The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 1/16//25 documents there are 72 residents living in the Facility.

(B)