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	IL6007892	A. BUILDING: _____ B. WING _____	C 04/06/2025

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S 000	Initial Comments Facility Reported Incident of 3/7/25/IL188602	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.690a) 300.1210b) 300.3240a) 300.3240c) 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. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999		

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S9999	Continued From page 1 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 care needs of the resident. 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) 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) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to protect a resident from allegedly being roughly handled, threatened, punched, and intimidated by an agency staff person; failed to assess resident of any injuries; and failed to train staff on screening, abuse prevention and investigation. This failure affected 1 (R1) of 3 residents reviewed for abuse from the sample of 3 and resulted in R1 abruptly ending her rehabilitation to discharge home due to the resident feeling unsafe and distressed for fear of agency staff's return.	S9999		

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Findings include:

R1 is an alert and cognitively intact resident with diagnoses listed in part with chronic kidney disease, spinal stenosis, hypertension and hyperlipidemia.

On 4/4/25 at 11:25 AM, R1 stated upon interview, "It was about 4 AM and I had to go to the bathroom, so I did it myself because it seemed there was no one around. No one was at the nursing station when I peeked outside my door plus the hallway was dark and a lot of the lights were turned off. I couldn't get my diaper back on, so I put a clean diaper on the bed to lay it down. I went to sit on it but couldn't put it on. I put my call light on so I could get help and a woman (with a winter hat and coat on) came barging in without a word, and just takes my diaper that I was sitting on and angrily rips it into shreds and then walks out of the room and then came back in with another diaper. She pushed me and took her fist and punched me twice in my back. I told her to stop, and I tried to grab the rail because I almost fell. I screamed because I was afraid of what this person was going to do to me. She said to me scream all I want but that that nobody was around. I tried to get her name, but she would not tell me, and I said please don't do that again and she told me to turn around and kept punching me while she tried to get my diaper on me. I said stop punching me or I'm going to call somebody. She said go ahead nobody is here. I was scared to death, and I didn't yell again because I did not see anyone anyway and I was afraid if I did scream again, she may have punched me harder again or even pull out a knife. When this nurse V4 (RN) finally came in it was around 6 in the morning, I was crying, my back hurt where she

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punched me, and I told him what happened. He said he'd take care of it, and he called in another nurse V5 (LPN supervisor) because he was in charge of the building, and he said that the woman isn't coming back. I didn't understand what that meant and was frustrated that they weren't around all night and now they tell me that woman is gone now, so their words were not "assuring" to me. That was the reason I left because I was scared and didn't know if she would retaliate against me for telling on her."

A written statement by R1 provided to V1 (Administrator) dated 3/7/25 at 3:45 AM, reads in part, "I got myself up and went to the bathroom and had bowel movement and took off my pull-ups as it was soiled and I cleaned myself up and came out and got a new diaper to put on, but I could not, so I laid it on the bed and sat on it. I pressed call button at 4:15 (AM) and a woman came in with her winter coat on and was yawning and I told her about my diaper and told me to sit on it again. She started pulling and ripped it to shreds. She left and came back with another one and said turn over and she put her fist and pushed me so hard I said stop you're going to push me on the floor. Then she turned me to the other side and pushed me again and I said stop and take blanket off me and then she left. I asked her name 3 times, and she would not tell me. So, 10 minutes later I put call button and said I want someone else here. She says no and I said I want to tell them you're about to push me off the bed. She says you're still on the bed, I said, "oh you're now getting smart with me, and she leaves and on her way out she says "Do not put call button on", so I did anyway because I thought maybe someone else was on duty but she did not come back for 1/2 hours..."

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On 4/4/25 at 11:00 AM, V10 (family member) stated that she never received a call pertaining to the incident involving the CNA V8 but rather was only informed to come in to the facility to sign papers about her mom receiving continued therapy and to obtain payer information. V10 stated when she came in to the facility around 1:30 PM on 3/7/25 her mom started crying to her and informed her that some staff person pushed her while in bed, punched her in the back, and then threatened her to not use the call light. V10 said she immediately went to tell the nurse to call the police and that was when V1 administrator came in to talk to her about the incident. V10 said she was upset that no one told her about what had happened to her mother until she came in to visit and that V1 appeared very nonchalant and indicated she would handle the situation after she had her lunch. V10 said, "My mom said she wanted to go home because she didn't feel safe and that no one was around all night to protect her, so I took her home."

On 4/4/25 at 12:30 PM, V4 (RN) stated upon telephone interview, "What happened was I was drawing blood for the whole house when I received (R1) she was in her chair next to her bed. She looked very distraught and was crying. It was about 5 or 6 in the morning because I was drawing every body's blood and I started around that time. The resident was trying to explain to me what happened, and she looked very guarded, almost as if she was in shock. She explained that V8 CNA on duty told her she should not ring the bell until the end of her shift or until she left. The resident is very alert, so she came across very credible, so I let the charge nurse V5 know when I saw him walk by and told him that we have a situation here and told him to come into the room. I told him because he was

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the supervisor at night. I have never seen this agency CNA before as there's been so much Agency staff lately. (R1) identified the CNA and I saw her just sitting by the couch near the nurses station. She had her stuff with her already like bags, notebooks and she had her winter coat on. We actually asked her to leave about 20 minutes to 7 AM after we called the administrator. Initially (V1-Administrator) didn't pick up but then she eventually called the facility back and said to write a statement later and so I did that and left." Surveyor asked if V4 did anything else with the resident to determine if she had any visible injuries or felt safe. V4 said, "I don't recall and I'm not familiar with the policy in that facility because I'm mostly PRN (as needed) and I don't get involved in the whole thing like this." Surveyor asked if V4 called the police. V4 said, " No I didn't call the police because I'm not familiar with their policies here. I just called the nurse in charge, and he called the administrator." Surveyor asked if V4 assessed the resident for any injuries. V4 stated, "I don't know, everything went so fast, and I probably should have but no I didn't."

A written statement signed by V4 dated 3/7/25 reads, "This morning when arrived to (R1) room, I noticed she (R1) was in tears and when I asked her why, she stated that she was scared. I asked her why she was scared. She (R1) responded that the CNA threatened her to not pull the call light. She also mentioned that she almost fell because the CNA was pushing her. She described what the CNA looked like, and it matched what she described. Supervisor (V5) informed and reassured her the event will be handled. Kept her safe". Signed by V4. (Absent from this statement is any physical assessment of any injuries or psychosocial assessment of the resident's well-being)

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There was no written statement taken by V1 (Administrator and abuse prohibition coordinator) for V5 (LPN night supervisor) who was directly involved during R1's initial reporting of allegation of abuse. Surveyor however was able to interview V5.

On 4/4/25 at 12:40 PM, telephone interview with V5 (LPN night supervisor) said, "There was an incident where an agency CNA was assisting a patient (R1). The nurse on duty (V4) called my attention to R1's room about a concern that the patient was scared about an Agency CNA. R1 described the CNA as African American, tall, wearing coat. I asked V4 what happened, and he described what the patient told him. What I can get from the nurse was that when the patient was being changed, she had a feeling she was going to fall from the bed during a diaper change. I guess she was being pushed too far at end of the bed and she was scared of the CNA and while being changed was pushed or hit by the CNA. When this all happened, I guess I was basically on 2nd floor doing rounds. I've been here since 2005 and this is the first time this has ever happened. The patient is very alert and is not confused at all. She was here for rehab. When I saw R1, she appeared very frightened and shaken up by the whole thing I could tell. " Surveyor asked V5 if there was any assessment conducted. V5 said, "No I don't recall doing that. We got so busy getting information from her and we called the administrator and left a message for her and by the time she called back, it was may have been about a quarter to 7 and the CNA (V8) was going home soon anyway but yes, I should have made sure V4 assessed her to see she was uninjured. " Surveyor clarified if there was any nursing assessment conducted as V1's

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abuse incident report indicated that there was one done. V5 stated, "No I don't recall that." Surveyor asked if the physician or family was notified of the incident. V5 said, "No I didn't call the family or doctor, we just called the administrator. I'm just supposed to call the administrator and I haven't encountered this situation before, so I didn't know what to do."

On 4/4/25 at 10:40 AM, V9 (Human resource director) said, "I don't handle agency staff paper work or trainings, just our own. We don't screen agency staff; they do the screening for us." Surveyor asked if agency staff screenings were reviewed by her, V9 said, "No I don't review any of their staff that they send, I didn't know I had to."

Surveyor requested to have V8's hire records and trainings provided to her by her agency, but no records were provided during the investigation.

V8 (agency CNA) could not be reached for interview during this investigation after several attempts were made.

V12 (NP) and V13 (Doctor) could not be reached for interviews during this investigation after several attempts were made.

Facility interdisciplinary notes showed no assessments were conducted on R1 to determine any injuries after alleged incident and no efforts were made or documented to reach family, physician or medical director.

Policy dated 9/27/24 titled "Abuse Investigation and Reporting" reads in part, "All reports of resident abuse, neglect, mistreatment shall be promptly reported to local, state and federal agencies and thoroughly investigated.

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S9999	Continued From page 8 Conclusions of investigations will also be reported, as defined by the facility policy. The individual conducting the investigation will, at a minimum: Review the completed documentation forms; Review the resident's medical record to determine events leading up to the incident; Interview the person (s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; Interview associates members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview other residents to whom the accused employee provides care or services; Review events leading up to the alleged incident. Witness reports will be obtained in writing, either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. Examine the alleged victim for any sign of injury, including physical examination and/or psychosocial assessment, if needed." (B)	S9999		