Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013213	A. BUILDING: ______ B. WING ______	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNWOOD PLACE	7000 NORTH MCCORMICK BLVD. LINCOLNWOOD, IL 60645

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S 000	Initial Comments	S 000		
S9999	Final Observations	S9999		

S 000 Initial Comments

Complaint Investigation: 2594441/IL192746

330.710a)
330.4240a)
330.4240b)
330.4240e)

S9999 Final Observations

Statement Of Licensure Violations:

330.710a)
330.4240a)
330.4240b)
330.4240e)

Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

Section 330.4240 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) (A, B)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility

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administrator. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. 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 observations, interviews, and record review, the facility failed to protect a resident's right to be free from physical abuse from nursing staff; failed to train nursing staff to immediately report alleged abuse to the abuse coordinator; and failed to suspending suspected perpetrator during an ongoing abuse investigation for one of four (R1) residents reviewed for abuse. This failure resulted in R1's hospitalization due to suspected elderly abuse resulting in bruises.

Findings include:

R1 is a 96-year-old male admitted to the facility on 10/23/2023 with diagnosis including but not limited to Heart Disease, Atrial Fibrillation; Hypertension (HTN); Depression; Anemia; Cerebral Infarction; Thyroid Disorder, Hypothyroidism; Acute Pain; Skin Redness; Shortness of Breath; Vitamin B12 Deficiency; Sleep Apnea; and Atherosclerosis.

R1's neurocognitive assessment dated 05/06/2025 shows that R1 has moderately

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impaired orientation and short-term memory; however, has no impairment related to communication.

R1's physical ability assessment dated 05/06/2025 shows that R1 requires total staff assistance with mobility and ambulation.

On 05/21/2025 at 10:53 AM V4 (Certified Nurse Assistant) said, "Recently, R1 had some pain in the right shoulder, but I don't know what happened. I worked day shift (6:00 AM - 2:00 PM) on 05/14/2025 and took care of R1 that day. R1 was completely fine when I was leaving (at 2:00 PM). Next time I took care of R1 was on Friday (05/16/2025). That's when I was told about R1's bruising and pain but the nurses were already taking care of it. I heard R1 had an x-ray and was given additional pain medications related to the new pain. R1 wasn't complaining of pain that much on my shift (05/16/2025, 6:00 AM - 2:00 PM). I know R1 has a history of seizures, but I've never witnessed him having one, so not sure if the shoulder pain was related to that."

On 05/21/2025 at 12:37 PM Surveyor observed R1 sitting in the wheelchair, next to the bed. R1 was alert and oriented to self and place. R1 said, "I'm sick and tired of telling the story. It was dark, they were helping me to get of the bed. V7 (Certified Nurse Assistant) grabbed my shoulder, and it gave me a lot of pain. They gave me pain medication after what happened. All I know, I have no pain now and feel alright. I don't feel safe (in the facility), it seems like they don't know what they're doing." R1 expressed he wanted to go back to bed, he's tired.

On 05/21/2025 at 12:40 PM Surveyor observed R1's injuries related to alleged incident that

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occurred on 05/14/2025. R1 had extensive dark purple discoloration on the right side on his torso, reaching from the right armpit all the way down to his waist and extending into the right flank area; yellow discoloration around mid-part of his right upper arm; and dark purple discoloration under the right armpit.

On 05/21/2025 at 1:28 PM V2 (Director of Nursing) said, "On Wednesday (05/14/2025), V8 (Licensed Practical Nurse) notified me that R1 was having shoulder pain with no visible injury. I told her to assess and treat the pain. V8 (LPN) administered scheduled pain medication and was going to reach out to hospice. On the following day, Thursday (05/15/2025) I was notified by V9 (Social Service Director), that R1 had shoulder pain and was saying someone had grabbed him. V9 (Social Service Director) had already notified V1 (Administrator) at that time and the internal investigation was initiated. Several staff interviews and R1's statements were inconsistent. R1 indicated that it might have been someone wearing a mask but unsure whether male, female, or no other details who grabbed his shoulder in a rough manner. I interviewed staff who gave direct care between of 05/14/2025 and 05/15/2025. V10 (Hospice Certified Nurse Assistant), V4 (CNA) and V5 (Certified Nurse Assistant) who assisted with R1's transfer, denied that R1 complained of any pain at any point during their shift. The first recognition of pain was when V6 (Certified Nurse Assistant) woke R1 up to get him ready for dinner. We ordered an x-ray on 5/15/2025, they didn't come until 05/16/2025 around 7:00 AM. There were still no obvious signs of injury, bruising, or swelling at that time. Later that day (05/16/2025), around 12:00 PM, the nurse noticed swelling to the right axillary area and light bruising to the upper interior arm

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On 05/21/2025 at 2:02 PM V7 (Certified Nurse Assistant) said, "I don't know much about the incident related to R1 because he hasn't been assigned to me recently. R1 prefers female CNAs, so I'm not assigned to care for him. Even when I work on the unit, I don't assist his assigned CNAs because of R1's preference for female CNAs. I don't remember last time assisting R1. I am not allowed to provide care to R1 due to R1 accusing me of rough handling in the past."

On 05/21/2025 at 2:07 PM V12 (Family Member) said, "I visited R1 on Tuesday 05/12/2025, he was fine. On 05/15/2025 I received a text message form V13 (Hospice Registered Nurse) stating that R1 said he was handled roughly and had a lot of pain. At the same time, I noticed I had a voicemail from V2 (Director of Nursing) stating "I'm here with V1 (Administrator), everything is fine, I just wanted to talk to you about R1." I called V2 (DON) first and was told that R1 is complaining of some pain and said he was handled roughly during the transfer with mechanical lift and asked to have an x-ray done. Mind you, R1 was a physician, I'm a physician, and my husband is as well. V2 (DON) sounded somewhat dismissive. I gave a verbal confirmation that it was ok to proceed with the x-ray. Later on, 05/15/2025, I talked to V13 (Hospice Registered Nurse) and she told me similar story. V13 said that R1 was handled roughly, he is in a lot of pain, and was given additional pain medication. In the afternoon, V8 (LPN) called me, not sure why, but I asked how was R1 doing and asked to get R1 on the phone. R1 told me, "My shoulder is killing me, and I can't wait to get the x-ray done." On Friday (05/16/2025), I found out the x-ray was negative. I reached out to V13 (Hospice Registered Nurse)

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to make sure R1's pain is well managed. My next conversation was on Monday, 05/19/2025, with V13 (Hospice Registered Nurse) and V14 (Hospice Social Worker) who came in to see R1 and saw large bruise. V14 called me and said, "I'm a mandated reporter and R1 has a large bruise and I'm going to report it". V14 also notified me that she spoke to her supervisor, and they advised her to call 911. R1 was then taken to the hospital for further evaluation. Yesterday (05/20/2025), I came into the facility and asked R1 what happened. R1 told me that V7 (CNA) moved him up in the bed, and R1 felt his muscle being pulled. R1 said, V7 (CNA) squeezed his arm and pulled him up in the bed, but he doesn't want any trouble for V7 (CNA). I saw the extend of R1's bruising too. I know R1 is on the blood thinner, but bruise of this size couldn't have happened only due to taking the blood thinner. I asked V8 (LPN) then for hospital records, I saw R1's x-ray and blood results and that blood work results were abnormal. In addition, R1 is on the blood thinner. R1 wasn't upset that it happened, but how it was handled. R1 didn't want to go to the hospital. I reassured him that it was necessary, and it was my responsibility. I also told V2 (DON) that some of R1's concerns about being handled rough are valid, as this happened in the past. R1 always says he's handled roughly, but I know R1, and if he asked to get an x-ray done due to pain, he must have been in a really bad pain. R1 has been in the facility for over a year and feel good about the facility; however, I can't deny that this didn't happen, and I'm not sure if it was intentional." Surveyor further clarified why would V7 (CNA) even assist R1 if he was forbidden to care for R1, V12 said, "Sometimes R1 gets confused, he might have gone back with his memories. First thing R1 told me when I came in was that he wanted to die, but

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now R1 is in much better place. When R1 first got to the facility (2023), R1 had really liked V7 (CNA). R1 started to complain and said they man handle him here and R1 is being yelled at by V7. R1 is frail and hard of hearing, so he has tendency to be tender. After R1's multiple complains, I mentioned it in the care plan meeting in February 2025 and V7 (CNA) was immediately taken of the case and never took care of R1 again."

On 05/21/2025 at 03:11 PM V6 (Certified Nurse Assistant), said, "I worked on 05/14/2025 2:00 PM - 10:00 PM. I worked with R1 on Tuesday 05/13/2025 and he was completely fine. Then on 05/14/2025, I first went to R1's room as usual, to get him up for dinner. It was around 4:00 PM. R1 said he doesn't want to get out of bed, R1 complained that someone grabbed him and he had pain in the right shoulder. I asked who grabbed R1, R1 didn't say who, he said someone. R1 is sometimes confused. I looked at his shoulder, but I didn't see any injury. I went and reported this to V8 (LPN) right away, and she came in to assess R1. V8 (LPN) didn't see any injuries either. Around 7:00 PM, I changed R1's brief and changed him into the gown to get him ready for bed. After that, I checked on R1 again, around 9:30 PM, R1 asked me to call V12 (Family Member) or send him to the hospital due to the right shoulder pain. I reported it to V8 (LPN) right away. The next time I saw R1 was on Friday 05/16/2025, and I saw bruises on the right side of his right side of his rib cage."

On 05/21/2025 at 3:20 PM V10 (Hospice Certified Nurse Assistant) said, "I took care of R1 on 05/14/2025 around 9:30 AM. R1 is a great helper, he was able to move his arms, legs and buttock. R1 was able to do everything during getting

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dressed and didn't complain of any discomfort or pain when I took care of him. On 05/15/2025, R1 was in pain, I was not able to provide any patient care due to pain. The facility staff reported to me that R1 was in pain because someone pulled on his shoulder too rough. There was definitely a difference in his behavior, he was complaining of a lot of pain."

On 05/21/2025 at 3:26 PM V8 (Licensed Practical Nurse) said, "I worked on 05/14/2025 03:00 PM - 11:00 PM. I'm not sure what happened, but around 4:30 PM, V6 (CNA) came I told me that R1 is complaining of shoulder pain because someone pulled on it. I went into R1's room, R1 told me someone pulled on his shoulder, and it hurts. R1 said to me someone pulled his arm, but didn't say who it was, R1 was said it was in the morning. When I performed the assessment, R1 had some pain during range of motion but no visible injury. I gave R1 scheduled pain medication. I went back some time later and R1 said his pain subsided. Then V6 (CNA) came to me again around 9:30 PM and said that R1 was complaining of severe pain in the shoulder. R1 said he wanted to go the hospital. I went to report it to V2 (DON) and I contacted the hospice. The hospice staff said that R1 cannot go to the hospital and ordered to give him additional pain medication. The hospice said they'll come out and assess R1 the following day. I reported R1's new pain to the incoming shift, said what had allegedly happened, and left for the day. I did not report it to anyone at first (05/14/2025 4:30 PM) because there was no visible injury, and I didn't think anything of it. I don't remember my last abuse training. If I hear of any alleged abuse, I should report. At first, I didn't think it was abuse, only pain, but the second time V6 (CNA) told me, around 9:30 PM, I reported it to the V2 (DON)

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and hospice staff."

On 05/21/2025 at 3:38 PM V13 (Hospice Registered Nurse) said, "I normally see R1 twice a week. Last week, I saw R1 on Wednesday (05/14/2025) around 1:30 PM for regularly scheduled visit. R1 was fine, didn't complained of any pain at that time, I left before 2:00 PM. Then around 10:30 PM, we received a call from the facility saying that R1 is complaining of shoulder pain, R1 was given scheduled pain medication, and that it wasn't effective, R1 was then given additional pain medication per our recommendation and was able to get back to sleep. I came in on 05/15/2025 to follow up on R1, because part of the report I received, was that he was in pain due to mishandling by facility staff. I came in around 11:30 AM to make sure the pain is well controlled. It was very unusual for R1 to be in pain that required PRN pain medication. When I got to R1's room he was laying on his right side, he complained of pain in his shoulder and said it was V6 (CNA) and another staff member who pulled him up in the bed. The staff wanted him to get up to eat. V6 (CNA) and another staff tried to forcefully get R1 up and out of bed for dinner. I looked at R1's shoulder, there was no visible injury, but very limited range of motion due to pain. R1 also told me he wanted to go to the hospital and was demanding an x-ray because he was convinced that there was something wrong with his shoulder. I contacted V12 (Family Member) and left her a message related to what occurred. I came back then on 05/16/2025, around 11:30 AM. I noticed bruising and reported it to the nurse on duty. The nurse said there was no bruising earlier when R1 got an x-ray. The nurse on duty followed me then to R1's room, we both assessed R1 and notice bruising all around right shoulder

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and under the arm pit, but R1 was in a lot of pain and couldn't lift his arm all the way up. There was no bruising on the torso at all at that time. I called V12 (Family Member) to let her know about new onset of bruising. I also reported it to V9 (Social Service Director). I believe I told her it was V6 (CNA) who allegedly hurt R1, but I'm not 100% sure. I left the facility then. I came back on Monday (05/19/2025) around 10:30 AM and that is when I noticed bruising got a lot worse, travelled to R1's right torso area and wrapped around to his right flank. I met with V14 (Hospice Social Worker). I know R1 is on a blood thinner, but the bruising was significantly larger to what I saw on on 05/16/2025. R1 kept saying they mishandled him, but I didn't ask again who did it. I notified my supervisor because I was unsure of what to do at this point. Around the same time, I called V12 (Family Member). V12 was very upset of what occurred. I put V12 on a 3-way call to call 911 and that's what we did. Shortly after, emergency services arrived at the facility, picked up R1, took him to the hospital, and police took statement form myself and I believe V14 as well. R1 has moments of confusion and has complained about V7 (CNA) in the past. It was brough up in the care plan meeting and the decision was made to make V7 (CNA) not be part of his team. From my understating V7 (CNA) hasn't been taking care of R1."

On 05/21/2025 at 4:42 PM V1 (Administrator) said, "I was notified of the incident on Thursday 05/16/2025 around 11:00 AM by V9 (Social Service Director) who said that V13 (Hospice Registered Nurse) notified her that R1 is complaining of pain and that someone was rough with him. There was no staff name that was brought up initially. I spoke to R1 shortly after I found out about the incident, R1 didn't tell me

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who rough handled him. V2 (DON) mentioned that she had a conversation with V12 (Family Member) and while they were debriefing in the late afternoon of 05/20/2025, V12 said that R1 alleged V7 (CNA) mishandled him last week. We followed up with V7 (CNA) today, around 11:00 AM and he denied assisting R1 in any capacity on 05/14/2025. I'm not sure what is the next step. V7 (CNA) is not suspended nor under an active investigation, investigation is closed. V6's (CNA) name never came up during the investigation. V6 (CNA) is not suspended nor under investigation. There were never any specific staff names that came up during the investigation. The window of the incident would have been on 05/14/2025 between 2:00 PM to 4:30 PM, but I was unable to narrow down to staff who might have been involved.

On 05/22/2025 on 8:43 AM V1 (Administrator) said, "I reopened the investigation and suspended V7 (CNA) yesterday in the early afternoon due to pending investigation. I know you mentioned V6 (CNA) but I didn't suspend her."

On 05/22/2025 at 9:14 AM Surveyor requested to see the facility camera footage to verify who was in R1's room during the window of the alleged incident (05/14/2025 between 2:00 PM to 4:30 PM) V3 (Executive Director) said, "The facility's cameras don't work properly, there is no footage available. We will suspend V6 (CNA) now that we found out that her name came up during the investigation."

On 05/22/2025 at 9:49 AM V13 (Hospice Registered Nurse) presented images to surveyor, showing the extent of R1's injuries, taken on 05/19/2025 12:11 PM. Images show pink

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discoloration around right armpit only. Images taken on 05/20/2025 11:09 AM show dark purple discoloration in the right armpit area and extensive dark purple discoloration on the right side of R1's trunk, reaching from the right armpit, down to the waist and extending to the right flank area.

On 05/22/2025 at 10:15 AM V5 (Certified Nurse Assistant) said, "I worked on 05/14/2025 from 6:00 AM to 2:00 PM. R1 was not assigned to me. I helped V4 (CNA) with R1's transfer before and after breakfast and then again, before and after lunch. There was nothing unusual about R1, he didn't seem to be in any discomfort, didn't complain of any pain. The last transfer I helped with was between 1:00 PM - 1:30 PM that day."

On 05/22/2025 at 10:21 AM V14 (Hospice Social Worker) said, "On 05/19/2025, I came into R1's room around 10:00 AM. The facility nurse, hospice nurse, and I were discussing R1's condition and the injury that has gotten worse over the weekend. I saw R1's injury that was reaching from the bottom of his right armpit to his right waist area, it was black and blue, and large, looked scary. R1 explained that staff was very rough with him and yelling at him during transfers to and from bed. R1 didn't specify when it occurred or who did it. We called V12 (Family Member) to let her know what's going on. I explained to V12 that this looks like elderly abuse, that I'm a mandated reporter, and went over the process of how to report abuse. V12 (Family Member) called 911, reported the abuse, and wanted R1 to go to the emergency room to get assessed for the abuse. After the emergency services arrived and R1 was out of the facility, I left. I was told by my management not to go to the facility anymore and I was taken off the case."

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On 05/22/2025 at 10:54 AM V9 (Social Service Director) said, "On Thursday, 05/15/2025, around 9:00 AM, I went to the nurses' station. The CNA and V13 (Hospice Registered Nurse) were in the nursing station. They informed me that R1 was complaining of pain in the shoulder because someone was rough with him. I went down to R1's room to see if I can get any information. R1 told me, it was a masked person who grabbed his shoulder and, as a result, R1 was having pain. R1 said, he didn't know who it was. When I asked when it happened R1 said it was at breakfast. After I talked to R1, I went and told V1 (Administrator) about what I heard from the V13 (Hospice Registered Nurse) and R1. I reported it because any alleged abuse should be reported to V1 (Administrator). I don't remember V13 (Hospice Registered Nurse) mentioning V6's (CNA) name or I might have not heard it. I didn't report any staff names to V1 (Administrator)."

On 05/22/2025 at 11:00 AM Surveyor conducted a follow up interview with V6 (CNA) who said, "When I first went into R1's room on 05/14/2025 (around 4:00 PM), R1 was confused, he thought it was breakfast. Whenever R1 wakes up, he thinks it is breakfast time. After R1 reported that he is in pain and doesn't want to get out of bed, I left him in the bed. I fed R1 in the bed. I never got R1 out of bed on 05/14/2025. I only changed he's brief before dinner (before 5:00 PM). We only use one person assist to change R1's brief, R1 can turn in bed. I never had any staff helping me with R1's patient care. R1 complained of pain around 4:00 PM because someone pulled his arm and then again later at 9:30 PM, R1 wanted to go to the hospital and talk to V12 (Family Member)."

On 05/22/2025 at 11:25 AM Surveyor conducted

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a follow up interview with V2 (DON) who said, "On the evening of 05/14/2025, V8 (LPN) told me that R1 was having pain, I did not ask why he was having pain, I did not find out that R1 stated he was roughly handled by staff until the morning of Thursday (05/15/2025), right after V9 (Social Service Director) spoke to V1 (Administrator), she told me about the alleged abuse."

On 05/22/2025 at 11:51 AM Surveyor conducted a follow up interview with V1 (Administrator) who said, "I went to see R1 on 05/15/2025. R1 said someone was rough with him. I tried to identify any staff but R1 could not tell me who it was, what they looked like, or when it happened. Then, I submitted initial report to the regulatory state agency by an afternoon of 05/15/2025. V2 (DON) and I started interviewing staff. First, staff who were present in the facility, and then continued with phone interviews. I also interviewed residents on the unit. The conclusion of the investigation was that I couldn't substation abuse happening, and it was clinically determined that R1 acquired injury of an unknown origin. I call the police when there is a crime such as theft, assault, battery, or when something is noticeably wrong. In R1's case, the police were already called by V14 (Hospice Social Worker). R1 being on hospice and based on V12's (Family Member) preferences, the inclination was do get diagnostic tests done in-house. Diagnostic testing was negative, there was nothing concrete except for abnormal blood levels that were consistent with someone who takes blood thinners that can result in bruising." Surveyor asked about facility abuse training schedule, V1 (Administrator) said, "The facility abuse training is done few times a year and as needed. As needed is considered after an alleged abuse incident or post audits. If staff hears about an alleged abuse, they should call

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me right away even if it's outside working hours, no text is accepted, they have to talk to me. If I'm not available, they should reach out to V2 (DON) or V9 (Social Service Director). If an allegation comes to a CNA's or nurse's attention, I prefer they report it to directly me, so I can make then the decision and move forward with appropriate steps. V8 (LPN) should have called me to report the alleged abuse on the evening of 05/14/2025."

On 05/22/2025 at 2:35 PM V11 (Attending Physician) said, "I haven't seen R1, so there was only a phone call interaction. I was notified on 05/16/2025 that a hospice patient (R1) was found to have right upper chest and right upper arm area bruising. V12 (Family Member) is concerned what could be the cause of bruising. I was told that an x-ray was done with negative result and the facility looked for my further advise of what this could be, so I order venous doppler to rule out upper extremity deep venous thrombosis. I was aware that R1 was on a blood thinner medication. I didn't really have a description of the injury; I was just told it's getting worse." Surveyor clarified if a resident who receives blood thinning medication is prone to acquiring spontaneous bruising, V11 said, "Not by itself. A resident cannot obtain bruise just from taking blood thinner, it usually occurs from trauma, such as blood pressure cuff, something has to happen, bruising should not occur spontaneously."

Progress note dated 05/14/2025 at 10:33 PM written by V8 (LPN) reads in part, "4:45 PM CNA informed nurse that (R1) was complaining of pain in the right shoulder. NOD went to assess, and no bruising noted, complained of pain when palpating but stated he thinks it muscular."

Progress note dated 05/16/2025 at 12:00 PM

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written by V15 (LPN) reads in part, "Writer notified by hospice that (R1) has bruising presented to right upper arm and upper extremity."

Progress note dated 05/19/2025 at 11:10 AM written by V16 (RN) reads in part, "Writer was made aware by NOD that the hospice RR and SS were with (R1) and were calling 911. Writer and NOD went to (R1's) room. SS from hospice had already called 911 and stated that the call was made with the POA via conference call."

X-ray report dated 05/16/2025 reads in part, "Procedure: Right shoulder, complete, 2+ views. Findings: There is no acute fracture or dislocation."

Police Report dated 05/19/2025 11:26 AM reads in part, "On 05/19/2025, at approximately 1126 hours, I [...], responded to a report of elder abuse at (the facility). Upon arrival, I made contact with (V13 Hospice Registered Nurse), who is the hospice nurse for (R1). (V13) stated (R1), was complaining of pain on his right shoulder on 05/14/2025, in the evening hours, due to (the facility) staff forcing him into a "Hoyer lift," and 'being rough with him." (V13) advised (R1) also confided in her that the nurse who caused the pain was "(V6 CNA)." (V13) advised (R1) was given (pain medication) on Wednesday night, in an attempt to ease the pain. V13 stated on 05/16/2025, at approximately 0700 hours, (R1) continued to complain of pain at which time (V12 Family Member), was notified. Shortly thereafter (V12) requested (R1) not be transported to the hospital for treatment and requested any X-ray and/or other treatment to be done in-house at the facilities. The tests completed on (R1) were negative for any injury, and following the

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completion of an X-ray, (V13) observed bruising under his right shoulder, which she stated was not there prior to the X-ray. (V13) stated (R1) was fine afterwards until 05/19/2025, at approximately 1126 hours, when he felt pain at which time (V12) requested the police for an elder abuse investigation. Upon arrival I observed the (local) Fire Department attempting to interview (R1), who appeared to be confused and could not speak clearly, so no interview was conducted at the time of the call. The (local fire department) confirmed the bruises on the right shoulder area of (R1), who was transported to (local) hospital for further treatment."

Hospital record dated 05/19/2025 2:25 PM reads in part, "(R1) came from (the facility). He is AO x 3 but hard of hearing. Possible elder abuse per patient as he was roughly handled. No concerns for fall. (R1) is on (blood thinner), so possible bleed due to minor trauma. Diagnosis: Suspected elderly victim of physical abuse."

R1's physician order dated 11/13/2024 reads in part, "Eliquis Oral tablet 2.5 MG; (1) tablet by mouth twice daily."

Per record review, V6's (CNA) last most recent abuse training before alleged incident (05/14/2025) on 11/21/2024.

V6's (CNA) reviewed with no identified concerns related to background check and disciplinary actions.

Staff schedule 05/13/2025 - 05/22/2025 shows V6 (CNA) assigned and providing direct patient care to R1 05/16/2025, 05/20/2025, and 05/21/2025 after alleged incident on 05/14/2025.

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The facility reported incident dated 05/19/2025 concluded "After conducting many interviews, abuse couldn't be substantiated. The (V10) hospice CNA denied being rough or anything happening out of the ordinary on the morning of 5/14, but she was the only one who wore a mask prior to the onset of pain. She also didn't transfer (R1) on that morning but did get him dressed while in bed. (R1's) facility assigned CNA, (V4) didn't wear a mask and the other another assisting CNA, was also not wearing a mask. Both independently deny any incident or (R1) complaining of any pain throughout their entire shift. (R1) also self-reported having a seizure that same day he started having right shoulder pain. All imaging has been negative, and the severity of bruising is consistent with his anticoagulated blood. (R1) does experience periods of confusion and wasn't able to identify what happened and the details of who may have been involved. It is unclear how he sustained the pain in his right shoulder followed by bruising."

The facility "Abuse policy" last reviewed 03/06/2025 reads in part, "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. All staff will be educated and held responsible to identify and report inappropriate behavior/abuse by others. If an employee is suspected to be involved in the incident, he/she is to be removed from the unit immediately and their statement obtained. The employee may not return to the community under any circumstances until the investigation has been finalized. Any persons witnessing or having

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