STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002026	A. BUILDING: _____ B. WING _____	C 06/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING CENTER	4314 SOUTH WABASH AVENUE CHICAGO, IL 60653

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S 000	Initial Comments FRI of 4/25/2025/IL192930	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 300.3210t) 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.

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 300.3210 General

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

These Requirements were NOT MET as evidenced by:

Based on interviews and record reviews, facility failed to follow their abuse policy to protect the resident's right to be free from physical abuse for one [R1] of [R2, R3] three residents. This failure resulted in R1 sustaining a bruised right eye, facial areas, and pain.

Findings include,

R1's clinical record indicates the following in part: R1 is a seventy-four-year-old male with medical diagnosis of Parkinson's Disease, chronic obstructive pulmonary disease, dysphagia, seizures disorder, contracture of left knee, contracture of right knee, major depression disorder and schizophrenia. Minium Date Set

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[MDS] section [C] indicates R1 is cognitively impaired. R1's MDS section [GG] indicates he needs maximal assistance with ADL Care, and transfers. R1 is unable to ambulate.

R1's Care Plan documented in part:
R1 has Parkinson's Disease.
R1 is unable to tolerate usual activities due to poor endurance.
R1 is at risk for abuse due t diagnosis of mental illness [2/13/24].
R1 require maximum assistance with mobility [2/18/25].
R1 has a seizure disorder [2/18/25].
R1 requires assistance from staff for transfers related to Parkinson's Disease.

R1's Progress notes indicated in part:
4/25/2025 6:55 am, Incident Note: R1 noted up in wheelchair, in dining area at vending machine, when physical altercation occurred with R2, and removed from area per security. R1 sustained bruising to right eye with swelling.

R1's Progress notes indicated in part: 4/27/2025 8:45 am, Daily Skilled Note
Note Text: R1 up in wheelchair, alert with confusion. Bluish discoloration with redness to sclera noted.

R1's Progress notes indicated in part: 4/25/2025 8:07 pm Daily Skilled Note, Note Text: R1 returned from eye clinic, no new orders noted.

R2's clinical record indicates the following in part:
R2 is a seventy-four-year-old male with medical diagnosis include but not limited to violent behavior, psychotic disturbance, mood disturbance, schizoaffective disorder, and hypertensive heart disease. Minimum data set

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[MDS] section C indicates R2 is cognitively intact, able to make his needs known. R2 MDS section [GG] indicates R2 is independent with ADL care, transfers, and able to ambulate independently.

R2's Progress Notes in part;
4/25/2025 07:52 am Behavior Note
Note Text: Staff reported to writer that R2 exhibited physical aggression toward a co-peer. Staff responded immediately, intervening to de-escalate the situation and ensure the safety of all residents. Individual was receptive to redirection. Staff provided counseling and educated R2 on the potential consequences of such behavior. No injuries were reported at this time. MD has been notified, and a petition has been initiated for the R2 to be transferred for further evaluation. R2 remains on 1:1 until the arrival of ambulance.

R2's Progress Notes in part; 4/25/2025 9:29 am, General
Note Text: R2 was transferred to Hospital. Petition, face sheet and med list sent with.

R2's Progress Notes in part; 4/25/2025 8:51 am: Daily Skilled Note
Note Text: Follow up call placed to hospital, spoke to Nurse, resident admitted with a diagnosis of aggressive behavior.

Interviews:

On 5/31/25 at 12:10 PM, R1 stated, "R2 hit me four times and he hurt my eye."

On 5/31/25 at 11:30 AM R2 stated, "R1 and I was in the day room and R1 got mad at me. R1 told me he was going to kill me, so I started hitting him. R1 then started hitting me, I threw him onto

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the floor and started stomping on him like this: [Surveyor observed R2 hold up his leg bending his knee and came down with his leg hitting his foot against the floor making a loud noise several times.] Then the staff stopped me from hitting R1, but R1 shouldn't have told me he was going to kill me."

On 5/31/25 at 11:45 AM, R3 stated, "I have not been abused at the facility nor have I witness abuse. I feel safe residing here at the facility."

On 5/31/25 at 1:30 PM, V3 [Licensed Practical Nurse] stated, "I was working on 4/25/25. I was passing medications in the day room. I heard yelling and looked up and seen R2 bent over with his arms swinging fast in the air back and forth. I yelled out for help and security assisted me with separating the two residents. R2 jumped on R1 and was punching him in the facial areas. R1's right eye and over his face was bruised black and blue in color. I called the V2 [Director of Nursing] she was in the facility, and she came up to the day room. V2 called V1 [Administrator], and he was made aware of the incident, I heard him on the phone with V2. R1 was sent out to an eye specialist the same day for emergency eye appointment."

On 5/31/25, at 1:50 PM, V4 [Licensed Practical Nurse] stated, "I heard a commotion coming from the day room, I saw R1's eye was swollen and black in color. I phoned the hospital eye clinic and got him the same day appointment. R1 went out the eye appointment and returned with no new orders."

On 5/31/25 at 2:10 PM, V5 [Certified Nurse Assistant] stated, "I did not witness the incident between R1, and R2 I was not on the floor."

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S9999	Continued From page 5 On 5/31/25 at 2:23 PM, V6 [Certified Nurse Assistant] stated, "I was in another residents' room providing ADL and when the incident occurred between R1 and R2." On 5/31/25 at 4:00 pm V7 [Social Service] stated, ", "R2 has a history of physical aggression. Upon R2's admission R2 appeared to be calm, but also exhibited inappropriate behaviors of physical touching, grabbing, of staff when being assisted with ADL's. I was not present during the altercation between R1 and R2, I heard R2 was hitting R1 in the face. R2 was petitioned out for psych evaluation. R2 had two other incidents of physical aggression toward other residents. R2 was sent out for another psych eval from a physical altercation with another resident and returned to the facility on 5/5/2. R2 is monitored one to one by social service staff. I am trying to find a nursing facility that can meet R2's needs. We will be monitoring R2 closely." On 5/31/25 at 3:00 PM, V2 [Director of Nursing] stated, "I had just walked into the facility, and I was phoned, and I went up immediately to the day room. R1 had a discolored right eye, R2 was sitting with one-to-one staff monitoring. I immediately phoned V1 [Administrator] and made him aware of the physical altercation. R2 has a history of physical aggression and was petition out for psych evaluation." On 5/31/25 at 3:15 PM, V1 [Administrator] stated, "The incident between R1 and R2 occurred on 4/25/25, not 4/24/25 that date was a typo mistake." [Surveyor asked V1; What was the conclusion of his investigation] V1 sated, "I do not remember what happened or if I was told about the	S9999		

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allegation, read the report, all the information you need is on there. The allegation of physical abuse was substantiated, R2 hit R1 in the facial area and note discoloration on R1's face. All new hires receive abuse training, and all staff receive abuse training annual and as needed.

Policy document in part:
Abuse dated 12/2024.
-This facility affirms the right of our residents to be free from verbal, physical, sexual, mental abuse neglect, misappropriation of resident property, involuntary seclusion, and exploitation.
Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident.
Mental abuse includes but not limited to humiliation, harassment, threats of punishment.

The facility should identity occurrence and patterns of potential mistreatment.
Physical abuse is he infliction of injury on a resident that occurs other than by accidental means and that requires medical attention.

Final Investigation Report:
The investigator will report the conclusion of the investigation within five working days.

(B)