### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** IL6014658

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<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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<td>S 000</td>
<td>Initial Comments&lt;br&gt;Complaint investigation #20184000/IL128021</td>
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<td>Final Observations&lt;br&gt;Statement of Licensure Violations:&lt;br&gt;300.610a)&lt;br&gt;300.3240a)&lt;br&gt;300.3240b)&lt;br&gt;300.3240e)&lt;br&gt;Section 300.610 Resident Care Policies&lt;br&gt;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.&lt;br&gt;Section 300.3240 Abuse and Neglect&lt;br&gt;a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act).&lt;br&gt;b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act).</td>
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**Attachment A**

**Statement of Licensure Violations**
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 were not met as evidenced by:

Based on observation, interview and record review the facility failed to protect a resident from physical abuse and failed to immediately report an alleged physical abuse involving staff and resident (R1) to the administrator and state agency. These failures resulted in R1’s blanket forcefully removed from her, R1’s both hands being forcefully held down on her chest against her will, and R1’s hair being grabbed and pulled. In addition, the failures resulted in the staff (V5) to continue to care for R1 after alleged physical abuse.

Findings include:

This applies to 1 of 3 residents (R1) reviewed for Physical Abuse in the sample of 6.

R1’s electronic medical record accessed on 10/22/2020 shows R1 had diagnoses that include Aneurysm, Metabolic Encephalopathy and Diabetes.

On 10/22/2020 at 9:06 AM, R1 was in bed awake. When surveyor asked how she was doing, R1
stated that man grabbed me, pulled me down and then he pulled my hair! It hurts here (pointing to her head) and here (pointing to her right arm) that man came again, don't let him come near me! Two dark purple bruises were noted on R1's left upper posterior and anterior arm. At 11:40 AM, this surveyor and V6 (Registered Nurse-RN) were again in R1's room. R1 told V6 that her right arm hurts. When V6 asked to rate R1's pain from 0 (no pain) to 10 (worst pain) R1 answered "5"

The facility initial report on Physical Abuse sent to the state agency dated 10/21/2020 at 12:00 PM, (a day after the incident) shows, "Allegation of Abuse, Incident Information, Resident alert with confusion, 76 year old. CNA (V4) reported that a CNA (V5) pulled the blanket off of the resident and the resident was moving her arms around and made physical contact with (V5). (V5) allegedly held the resident's arms on the resident's chest and tugged on the resident's hair pulling it. Investigation initiated.

10/22/2020 at 0:15 AM, V4 (Certified Nursing Assistant-CNA) said she witnessed the physical abuse that was done to (R1). V4 (CNA) said on 10/20/2020 between 9 and 10 AM, she was asked by V5 (CNA) to help get up (R1). V4 said when they entered R1's room, R1 was in bed sound asleep. V4 said without saying anything, V5 pulled R1's blanket from R1 as his way of waking R1 up. R1 was awakened and startled. V4 said V5 grabbed R1's hands and forcefully placed R1 hands on R1's chest. R1 was fighting to get both of her hands loose from V5. R1 was cursing V5, "son of a b------, mother f------, let go of me! Let go of my hand! Why are you doing this to me?" Mother f------. V4 stated "I told him to stop, I told him, knock it off! Stop!, let go of her hands!" V4 said V5 ignored her. V4 stated "I felt
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so bad, I was angry, he had R1's hand pinned down against her will." V4 said R1 continued to yell at V5 and was trying her best to free her hand. When R1 finally had her left hand loose, R1 reached out and scratched V5. V5 then grabbed a chunk of R1's hair then pulled at it. V4 said, she was so upset of the abuse she witnessed and V4 was in tears while they were taking care of R1. R1 was sent to therapy. V4 said she did not report this incident until the next day because she was afraid to lose her job and V5 was everyone's friend. V4 said V5 continued to be R1's CNA that day for 7.5 hours when the abuse occurred. V4 said she knew R1 might not be safe but she was more scared of losing her job. V4 said she was not able to sleep that night, V4 said the next day she was at work, and V5 was again assigned to R1. V4 said she decided to tell V8 (Scheduler). V4 said she texted V8 and asked her if they can talk. V4 said she did not report the incident to anyone until the next day. V4 said V5 continued to be R1's CNA that day (10/20/2020).

On 10/22/2020 at 12:45 PM, V8 said that on 10/21/2020 at around 10 AM, she received a text from V4 that she wanted to talk. V8 said V4 reported to her the abuse incident the day before between R1 and V5. V4 told V8 that V5 pulled R1's blanket from her to wake R1 up, grabbed both of R1's hands forcefully and pinned them down on her chest and V5 pulled R1's hair. V8 said she asked why she waited another day before reporting the incident. V8 said V4 told her she was scared. V8 said she reminded V4 that Abuse has to be reported right away. V8 said she went to report the Abuse allegation to V1 (Administrator) and V2 (Director of Nursing).

On 10/22/2020 at 1:00 PM, both V1
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(Administrator) and V2 (Director of Nursing-DON) said V8 informed them that V4 just reported an allegation of Physical Abuse regarding R1 and V5. V1 said he immediately interviewed V4 and asked why she waited a day reporting the incident of Abuse. V1 said V5 was allowed to continue to take care of R1 even after the abuse incident because V4 did not report the abuse immediately. V1 said V5 was suspended right away and the police was called. The initial report was sent to the state agency. V2 said Abuse need to be reported immediately so the resident is protected from the accused staff.

On 10/22/2020 at 11:11 AM, V7 (police officer and complainant) said he was in the facility yesterday (10/21/2020). V7 said a staff battered a resident. V7 said this physical abuse incident was witnessed by another staff. V7 said this CNA yanked the blanket from the resident meaning forcefully removed the resident's blanket. The resident became agitated because of this. Resident called the CNA son of a b---- and mother f----. The CNA pinned both of the resident's hands to her chest, physically restraining the resident's hands. The CNA also grabbed the resident's hair and pulled at it. V7 said their own investigation is ongoing to determine what charges to be filed. This incident was not reported immediately. V7 said who knows what else this CNA did to the resident.

On 10/22/2020 at 1:00 PM, V1 (Administrator) said an allegation of physical abuse was reported to him yesterday, 10/21/2020. V1 said the abuse happened the day before (10/20/2020) and it was witnessed by another staff. V1 said he immediately initiated the investigation on 10/21/2020 (A day late). V1 said he spoke to R1. V1 said R1 told him "This guy came to my house,
grabbed me and pulled my hair." (R1 pointing the back of her hair) V1 said R1 told him her head hurts. V1 said R1 was able to describe the accused staff, (V5) "Tall, dark hair and wears a pony tail." V1 said although R1 has some confusion, R1 was able to describe the accused staff. R1's description fits the accused staff. V1 said the accused staff does wear a pony tail. V1 said the staff (V5) was suspended and the police were called. V1 said R1's family and physician were also notified. V1 said an initial report had been sent to the state agency. V1 said Abuse was never tolerated in the facility.

On 10/22/2020 at 11:24 AM, V5 (CNA) said he was R1's CNA on 10/20/2020. V5 said he was told that R1 needed to get up for therapy. V5 said he asked V4 to help him. V5 said when they entered the room, R1 was in bed asleep. V5 said he removed R1's covers. V5 said he took both of R1's hands, held R1's hands by the wrist and placed them on R1's chest. V5 said he held R1's hands so it was easier for him and V4 to take care of R1. V5 said R1 can get combative sometimes. V5 said R1 was trying to swing at him so he continued to hold R1's hands against R1's chest. V5 said he cannot remember if V4 told him to stop. V5 said he cannot recall pulling R1's hair. V5 said after R1 was provided care, R1 went to therapy. V5 said he was R1's CNA from 6 in the morning until 2:30 in the afternoon that day (10/20/2020). V5 said the next day, his assignment was again on R1's hall until around 11 AM. V5 said he was sent home on 10/21/2020 around lunch due to allegation of abuse.

On 10/22/2020 at 11:50 AM, V11 (Occupational Therapist-OT) said she was R1's OT on 10/20/2020. V11 said she noticed R1 was sad and seemed upset while receiving therapy on
10/20/2020. V11 said she was wondering what was going on. V11 said R1 did not say anything to her. V11 said the next day, she heard that a staff member was suspended because of an incident with R1 regarding abuse.

On 10/22/2020 at 2:00 PM (Registered Nurse-RN) said she was R1's regular nurse. V6 said R1 got agitated only if she does not know what was going on. V6 said staff should explain to R1 first what kind of care they will provide and R1 would be fine. V6 said yesterday she was informed by V1 (administrator) that V5 (CNA) was being sent home because V5 was accused of abuse. V6 said she was instructed by V2 (Director of Nursing) to complete a skin check on R1. V6 said R1 had bruises on her lower legs. V6 said she did not notice the 2 bruises on R1's left upper arm on 10/21/2020. The bruises are new. V6 confirmed that V5 was R1's CNA and V5 continued to be R1's CNA from 6 AM to 2 PM on 10/20/2020 when the abuse occurred. V6 said abuse is not allowed in the facility. V6 said residents' have rights and these rights cannot be violated. Residents need to be protected. Residents cannot be abused or mistreated.

R1's skin assessment dated 10/22/2020 shows that R1's left upper arm (posterior) bruise measures 8x11 centimeters. The anterior bruise was measured "a dime size". The same skin assessment shows R1's bruises came from trauma. R1's skin assessment on 10/21/2020 did not show any bruises on her left upper arm. R1 has numerous bruises on her lower legs.

On 10/22/2020 at 1:00 PM, V2 said she was informed of the physical abuse yesterday 10/21/2020. The incident happened on
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10/20/2020. V2 said she instructed the nurse to complete a body check. V2 said R1's bruises in R1's left upper arm are new. V2 said bruises can develop later. V2 said they are still in the process of investigating the abuse that occurred on 10/20/2020.

On 10/23/2020 at 10:40 AM, V10 (nurse practitioner) said if a resident is combative, agitated, or has behavior, staff should step back and let the resident calm down and reapproach later. Abuse need to be reported immediately.

The facility's Abuse Policy with a revised date of 9/24/18 shows "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property."

(B)