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WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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S 000	Initial Comments Complaint Investigations: #2171081/IL131072 #2171216/IL131216 #2171256/IL131259 #2171345/IL131361	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210b) 300.1210d)3) 300.1220b)2)3) 300.3240a) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.
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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services

b)The DON shall supervise and oversee the nursing services of the facility, including:
2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status,

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discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.
Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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)

These requirements were not met evidenced by:

Based on observation, interview and record review, the facility failed to protect residents from mental, physical, and sexual abuse. Also, the facility failed to thoroughly investigate, prevent further potential abuse while investigating, and report the results of investigations to the State

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Survey Agency within five working days of the incident.

As a result of this failure, R9 and R10 were exposed to abusive behaviors from R2 and R13 was physically attacked by R12.

The findings include:

Facility Daily Census, dated 2/17/21, shows the total resident census was 191 residents.

MDS (Minimum Data Sets) show R1 (12/22/20), R6 (2/2/21), R7 (2/23/21), and R18 (1/18/21) were all cognitively intact. MDSs show R8 (2/1/21), R9 (2/10/21), and R13 (1/26/21) had cognition that was moderately impaired, however were interview able.

1. Face sheet, dated 2/19/21, shows R2 was 38 year old male with diagnoses including impulse control issues, cerebral palsy, disorder of psychological development, unspecified lack of expected normal physiological development in childhood, restlessness and agitation, intellectual disabilities, and major depressive disorder. R2 was originally admitted to the facility on 1/7/21 and R2 was re-admitted again to the facility on 2/9/21.

Prior facility records show R2 had behaviors of agitation, pacing, throwing items on the floor of the hallway, publicly disrobing and wandering in the facility, impulsiveness, behavioral disturbances, throwing food, taking drawers out of dressers and placing them on the floor, wandering into other resident rooms, waving scissors at staff, and playing in his feces.

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S9999	Continued From page 4 Prior facility psychiatric nurse practitioner notes, dated 12/11/20, shows, "Nursing reports episodes of disrupted behavior. R2 broke two televisions, urinating and defacing in inappropriate areas." The note shows R2 began on Risperdal and PRN Ativan for agitation. R2 diagnoses at the time of the assessment included impulse control disorder, severe cognitive impairment, developmental disorder, and cerebral palsy. Prior facility nursing notes show R2 showed behaviors of agitation, pacing, throwing items on the floor of the hallway, publicly disrobing and wandering in the facility, impulsiveness, behavioral disturbances, throwing food, taking drawers out of dressers and placing them on the floor, wandering into other resident rooms, waving scissors at staff, and playing in his feces. The prior facility notes show the facility sent out referrals to behavioral health hospitals and the physician increased R2's doses of Risperdal and Clonidine with little to no effects. Prior facility social services note, dated 1/6/21, which shows, "spoke with R2's cousin in regard to resident's increasing behaviors. Notified [family] R2's behaviors are increasing, and the facility cannot handle these types of behaviors resident is displaying. [Family] stating resident would need to be sent to another facility." R2 was admitted to the facility on 1/7/21 with this history of abusive, aggressive behaviors. Review of R2's clinical record failed to show R2 was assessed for the risk of abusing residents or for the risk of being abused, related to his behaviors. No individualized treatment plan was identified to address R2's history of behaviors.	S9999		

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Nursing admission progress note, dated 1/7/21, shows, "According to nurse to nurse report from facility resident is having behavior issues as alert and oriented times 1, he doesn't know what he is doing."

Care plan, dated 1/7/21, shows R2 was receiving psychotropic medication to help manage and alleviate agitation and aggressive behavior, mood swings, mood liability, anxiety, neurosis, anxiety disorder, insomnia, and sleeping disorder problems. Care plan interventions, dated 1/7/21, include "13. Continue to monitor and attend needs due to developmental delay for safety and precaution. Visual supervision provided for continuity of care related to safety concerns."

Nursing note, dated 1/8/21, shows, "R2 was restless, going into several rooms and throwing objects in the hallway, able to redirect but goes back to doing the same thing after a few minutes. Spoke with nurse practitioner and she informed writer that was part of his behavior before coming to this facility." Social Services note, dated 1/18/21, shows, "Resident continues to be redirected by staff members due to his impulsive mood/behaviors (Resident exhibits very destructive behavior, throwing objects into the hall way from his room, digging into the garbage can and throwing trash out onto the floor in the hall way, resists care some of the times and is not easily redirectable at times." No interventions are discussed regarding R2's identified behaviors or history of behaviors.

Social Services Screening Assessment for Indicators of Aggressive and/or Harmful Behavior, dated 1/10/21, shows R2 was "Potentially able to integrate into the peer community, minimal risk for aggression. Dementia related interventions

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include re-orientation, re-assurance, emphasis on safety/security. SMI related interventions include stress management/stress relief, improving communication skills, harm reduction. The assessment showed R2 was assessed as not having concerns regarding awareness/insight/judgement/reasoning concern in spite of a diagnoses of impulse disorder, cerebral palsy, disorder of psychological de elopement, and unspecified symptoms and signs involving cognitive functions and awareness, dated 1/7/21 on R2's face sheet. The assessment also shows R2 did not have a history of, or recent episode of, aggressive/agitated behavior (aggression towards others including destruction of property) in spite of behaviors documented in prior facility transfer documents.

No further assessments / re-assessments were identified in R2's clinical record despite R2 being sent to the hospital after punching R10, having worsening aggressive behavior at the facility, and being readmitted back to the facility on 2/9/21.

On 2/19/21 at 11:23 AM, V5 (Patient Tech) stated the prior week he found R2 standing in R10's room masturbating while R10 was asleep in his bed and was redirected by V5. V5 stated he walked down the hall to tell V6 (CAN - Certified Nursing Assistant). V5 stated V6 told V5 to report the incident to the V4 (Business Office Manager). V5 stated he walked to the front office and reported the incident to V4. V5 stated V4 responded, "We need to tell V1 (Administrator) about that because that is sexual assault." V1 was not in her office, so V4 told V5 to go back to R2 and V4 would tell V1 when V1 returned to the office. V5 stated he waited for V1 to come talk to him for some time but had to leave at the end of his shift for a physician appointment.

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S9999	Continued From page 7 On 2/22/21 at 3:53 PM, V11 (Social Services) stated social services should have completed a reassessment of R2's Screening Assessment for Indicators of Aggressive and/or Harmful Behavior within 24 to 48 hours of R2's readmission on 2/9/21. V11 stated when R2 was readmitted, the plan of care for R2 was R2 was to have 24 hour 1:1 supervision. V11 stated she was not aware R2 masturbated in a resident's room or heard he was taking items out of others' rooms until just recently. V11 stated when R2 was initially admitted on 1/7/21, R2 was not having behaviors like those described at the previous facility and the only aggressive behavior reported to her was when R2 hit R9. Care plans, dated 1/14/21, shows R2 had a history of aggressive, inappropriate, attention-seeking and/or maladaptive behaviors, conflicts/altercations with others, threatening behavior, verbal/physical aggression, and acting impulsively, erratically. R2's behaviors included wandering, pacing, and motor agitation, verbal behavioral/aggression, physical behavior/aggression, and socially inappropriate and/or maladaptive/disruptive behavior. Care plan, dated 1/14/21, shows R2 had a cognitive impairment related to mental illness, mental retardation, which manifested in impaired decision making, poor logic, poor ability to understand cause and effect, poor ability to recall names/places/objects, poor judgment/insight/reasoning/impulse control, and poor ability to control anger and frustration. Care plan, dated 1/19/21, shows R2 was developmentally disabled with symptoms which included going into other peers' rooms. The care plans fail to show individualized approaches related to R2's behaviors.	S9999		

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Review of R2's clinical record, including assessments and care plans, fail to show R2 was assessed for the risk of being abused, or for the risk of abusing other residents, related to his behaviors.

Nursing note, dated 1/11/21, shows R2 "exhibits very destructive behavior, throwing objects into the hallway from his room, digging into the garbage can and throwing trash onto the floor in the hallway, resists care some of the times and is not easily redirectable." No new or revised interventions were identified regarding R2's destructive behaviors.

Social Services Admissions note, dated 1/18/21, shows, "Resident continues to be redirected by staff members due to his impulsive mood/behaviors (Resident exhibits very destructive behavior, throwing objects into the hall way from his room, digging into the garbage can and throwing trash out onto the floor in the hall way, resists care some of the times and is not easily redirectable at times." No new or revised interventions were identified regarding R2's ongoing behaviors.

Final Incident report, dated 1/19/21, shows R9 "stated that [R2] entered her room and picked up her belongings. When she tried to get back her belonging from resident [R2], he accidently pushed her." The report shows R2 was sent to the hospital for further psych evaluation and R2 was to be moved to another wing in the facility upon return from the hospital. Investigation statement shows R9 stated, "When he came into my room and took my belongings, I tried to get it back from him and that is when he hit me in the

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S9999	Continued From page 9 shoulder." 2. On 2/9/21, R2 was accepted back at the facility with a plan of care that included 24 hour 1:1 supervision to prevent further incidents. On 2/18/21 at 2:00 PM, V1 (Administrator) and V2 (Director of Nursing) stated the facility agreed to accept R2 back at the facility with a plan in place for 24 hour 1:1 direct supervision of R2 by staff. The clinical record fails to show R2 was reassessed for Indicators of Aggressive and/or Harmful Behavior following his readmission on 2/9/21. On 2/18/21 at 1:32PM, R8 stated that R2 was in her room three times the prior day and that R2 touched her on the shoulder. R8 stated, "I don't want him in my room anymore! I don't want him touching me!" R8 stated R2 also took a beverage from her room. Initial incident report, dated 2/18/21, shows, "Residents reported they feel unsafe around R2. He currently has a one to one with him. Reports he is still walking around and in and out of resident rooms. Investigation question asked to interviewed residents showed, "If a resident makes you feel uncomfortable, do you know who to talk to?" The initial report did not show residents were assessed if they felt safe at the facility with R2. On 2/18/21 at 12:00 PM, R1 stated he previously told V25 (Activities Director) he did not feel safe at the facility. R1 stated, "I don't know what this guy is up to!" R1 stated he witnessed R2 masturbating in the hall, but no staff intervened. R1 stated R2 was standing in the hall naked from the waist down and his pants were around his ankles. R1 stated he was aware R2 was sent out of the facility previously for hitting another resident. R1 stated he turned in a concern form to	S9999		

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the front desk on 2/17/21 expressing his fear of R2 entering R1's room unsupervised however R1 had heard no response from the facility. Review of facility concern forms fail to show R1's concern form turned in on 2/17/21. Review of facility incident/abuse investigations fail to show R1's safety concerns regarding R2 were reported to the abuse coordinator/administrator or were investigated.

On 2/18/21 at 12:40 PM, R2 was observed in his room unsupervised by any facility staff.

On 2/18/21 at 1:07 PM, R6 stated he did not feel safe with R2 entering his room unsupervised. R6 stated R2 entering his room unsupervised was a recurring occurrence and the facility was aware of it. R6 stated R2 was usually supervised until about 5:00 PM and, after 5:00 PM, R2 would chronically enter R6's room unsupervised. R6 stated he asks R2 to leave his room "with volume." R6 stated, "I don't feel threatened by some of the wanders, but because of the woman saying he was there three times and put his hands on her, I don't feel safe. I feel OK now that they are supervising, but if there is no one there he acts out." R6 stated R2 had been at the facility before and was aware R2 hit another resident and that R2 masturbates and walks around naked in the facility. R6 stated he reported his concerns regarding R2 to administration when R2 touched the resident residing across the hall from him. R6's stated the facility apologized and stated they took action to have staff monitoring R2. R6 stated he was concerned R2 would become a resident at the facility because R6 did not feel the facility was capable to meet R2's needs.

On 2/18/21 at 2:30 PM, V9 (Social Services)

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stated she immediately went to R8's room to interview R8 about the incident the prior night when R6 informed administration of the incident. V9 stated when she arrived, R2 did not have staff 1:1 directly supervising him. V9 stated she interviewed R8 who stated R2 only touched her shoulder and did not injure R8. V9 stated R8 told V9 that R2 also drank R8's beverage and while in R8's room unsupervised. V9 stated she had previously heard R2 had disrobed and masturbated at the facility, but she was not aware of any witnesses to R2's behavior. V9 stated R2 was immediately placed on continuous, 24 hour 1:1 supervision when he was readmitted to the facility on 2/9/21.

On 2/18/21 at 3:58 PM, R7 stated, "He was just here about an hour ago!" R7 stated no staff were with R2 when he entered R7's room. R7 stated R2 chronically enters R7's room unsupervised and has tried to remove R7's bag from his room. R2 also took a sock from R7's dresser and left the room on one occasion. R7 stated one-night R2 came in no less than fifteen times unsupervised. Rj7 stated he reported R2 to the facility administration and the administration told R7 that R2 was taken care of. R7 stated R2 came into R7's room unsupervised approximately an hour later and left an empty milk carton on R9's dresser.

Review of staff worked schedules, dated 2/9/21 - 2/18/21, show no staff were consistently scheduled to be assigned as 1:1 staff designated to supervise R2.

On 2/18/21 at 2:00 PM, V2 (Director of Nursing) stated staff were not specifically scheduled to perform 1:1 supervision 24 hours a day for R2.

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S9999	Continued From page 12 V2 stated the staff assigned to the units would designate an individual to monitor R2 and the staff would take turns providing supervision for R2 throughout the shift as necessary to cover for each other. On 2/19/21 at 11:00 AM, R9 stated several weeks prior R2 had come into her room twice already that day and R9 told R2 to get out of the room each time. The third time R2 entered R9's room, R9 got upset, stood up, walked within three feet of R2, shook her finger at R2, and said, "No NO!" R9 stated R2 hit R9 in the upper torso near her shoulder with a closed fist. R9 stated the area R2 hit hurt when she was hit and hurt afterward. R9 stated, "It hurt me! You could tell something wasn't right with him. He was very unpredictable. He caught me off guard! It shocked me! Then I got really mad!" R9 stated she told the facility R2 hit her and stated, "He did not accidently push me! He intentionally hit me! He knew what he was doing! The was no accident with what happened. They knew what I was saying was true and they knew I didn't initiate it! He could have walked right in here at night because we don't have locks on the doors! I just thought of that!" On 2/19/21 at 11:23 AM, V5 (Patient Tech) stated the prior week he was passing lunch trays and was looking for R2 so he could deliver R2 his tray. V5 stated he found R2 standing in R10's room masturbating while R10 was asleep in his bed. V5 stated he was passing lunch trays at the time and no staff was 1:1 supervising R2. V5 stated he redirected R2 to R2's room, placed him in bed, and walked down the hall to tell V6 (Certified Nursing Assistant). V5 stated V6 told V5 to report the incident to the V4 (Business Office Manager). V5 stated he walked to the front	S9999		

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office and reported the incident to V4. V5 stated V4 responded, "We need to tell V1 (Administrator) about that because that is sexual assault." V1 was not in her office, so V4 told V5 to go back to R2 and V4 would tell V1 when V1 returned to the office. V5 stated he waited for V1 to come talk to him for some time but had to leave at the end of his shift for a physician appointment.

On 2/19/21 at 12:01 PM, about a week prior, V4 stated she asked V1 to go speak to V5, however did not express to V1 that there was a report of an allegation of abuse regarding R2. V4 stated she told V1 that R2 was having behaviors and V1 needed to talk to V5. V4 stated the incident did not come up in the daily administration meeting at the end of the day.

On 2/19/21 at 12:13 PM, V1 (Administrator) stated about a week ago, V4 told her she needed to go see R1 regarding having inappropriate behaviors. V1 stated she immediately went to the nursing station and talked to the nurse who told V1 that R2 was having behaviors masturbating but did not tell V1 that R2 masturbated in R10's room while R10 was in bed sleeping. V1 stated nursing reassured V1 that R2 had 1:1 supervision and R2 was redirected and the behaviors were managed. V1 stated the nurse told V1 that the physician had been called. V1 stated she read the nursing note which did not describe R2 masturbating in R10's room. V1 stated she was never told R2 was in R10's room masturbating, and therefore did not initiate an abuse investigation.

Final Incident report, dated 1/19/21, shows R9 "stated that [R2] entered her room and picked up her belongings. When she tried to get back her

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belonging from resident [R2], he accidently pushed her." The report shows R2 was sent to the hospital for further psych evaluation and R2 was to be moved to another wing in the facility upon return from the hospital. Investigation statement shows R9 stated, "When he came into my room and took my belongings, I tried to get it back from him and that is when he hit me in the shoulder." The final incident report failed to show R2 hit R9 or that R9 was hurt when R2 hit her. The final report also failed to show other residents were interviewed to identify any other victims of abuse by R2.

On 2/22/21 at 4:16 PM, V10 (LPN - Licensed Practical Nurse) stated V5 told her R2 was "standing in the doorway" of the next-door resident's room masturbating. V10 stated she asked V5 if R2 was in the resident's room and V5 stated R2 was standing in the doorway.

Nursing note, dated 2/15/21, shows, "Staff reported that resident was observed exhibiting inappropriate sexual behavior but was stopped immediately. 1:1 in progress. Encouraged to staff in his room this shift."

Initial incident report, dated 2/18/21 at 2:00 PM, shows, "Residents reported they feel unsafe around R2. He currently has a one to one with him. Reports he is still walking around and in and out of resident rooms. Investigation question asked to interviewed residents showed, "If a resident makes you feel uncomfortable, do you know who to talk to?" The initial report did not show residents were assessed if they felt safe at the facility with R2.

Initial Incident Investigation, dated 2/19/21, shows, "Staff person reported to the surveyor that

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he witnessed R2 in the room of R10 standing over top of him masturbating. R10 was asleep and unaware. "Interview of V5. He was passing trays, witnessed R2 standing in the room of R10 masturbating. V5 went into the room and redirected R2 back to his room and V5 reported this to the nurse. V5 stated resident was asleep and unaware of what was happening. Full investigation to follow."

The clinical record showed R12 was admitted to the facility on 10/27/20 with a diagnosis of dementia with behavioral disturbances, anxiety disorder, and alcohol abuse. Physician note, dated 10/28/20, shows R12 was sent to the hospital from his prior facility after being accused of grabbing another resident's breast.

Physician note, dated 11/16/20 shows R12 had reports of alleged inappropriate sexual behavior of touching another female resident's breast. R12 was sent to the hospital and returned with no further recommendations. The note shows R12 was to continue his Depro-Provera (Medroxyprogesterone Acetate Suspension) injections monthly every Monday and staff were to continue to monitor for mood, behavior, and mental status.

Final Incident Investigation, dated 11/18/20, shows on 11/14/20, R12 was accused by two residents of touching them inappropriately. The report concludes R8 had inconsistencies with her statements and R18 reported her allegation only when overhearing R8 report her allegation. Investigation Interview, dated 11/14/20, shows R8 was not sure at first what incident the interviewer was referring to when questioned, however R8 provided a description and a recount of the incident once she was clear about the subject

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and stated the man she described was standing over her when she woke from a nap with his hand on her crotch. However, an investigation summary refers to additional information not recorded on R8's interview regarding the incident. Investigation interview with R18 showed no inconsistencies and shows R12 was accused of hugging R18 and touching R18's breast.R18 stated she then went to the nurses station to report the incident and told the nurse she wanted to speak to Social Services. The investigation fails to show R12 had a history of sexually inappropriate behaviors, was receiving Depro-Provera to treat his sexually inappropriate behaviors and fails to show that other facility residents were interviewed to identify other possible victims of R12.

On 2/24/21 at 3:50 PM with V20 (CNA), R13 stated on 2/23/21 at approximately 8:30 PM, R13 was sitting on the right side of his bed watching television and R12 was asleep in his bed with his television on. R13's bed was the middle bed in a three-bed room. R13 stated R12, who resided in the bed by the window, began to talk in his sleep and yell out, so R13 called out to R12 that he should turn his television off and go back to sleep. R13 stated R12 stood up, walked past R13's bed, walked toward the room door, and walked back to R13 sitting in his bed with metal knife in his hand. While R12 was walking around the room, R13 stated R12 was threatening R13 saying, "I kick your ass!" and "I'm gonna kill you M___F___." R13 stated R12 stood in front of R13 and tried to stab R13 three times with the metal knife. R13 had three abrasions on his stomach. One abrasion was an approximately 1 cm (centimeter) cut above his right nipple that extended into the tissue of his nipple. The area around the cut was dark blue purple. The second

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abrasion was approximately three inches long to the right of R13's navel. The third abrasion was above the second abrasion on the right of R13's torso and was approximately two inches in length. R13 stated R12 stopped attempting to stab R13 because R12 was kicking R13 away. R13 stated he stood up, walked past R12, and walked out to the nurse's station to report what had happened. R13 stated the police were called and came to investigate as did several staff. R13 stated they all asked R13 if R12 had a plastic knife. R13 stated he continued to reiterate R12 stabbed him with a metal knife. R13 stated the police and staff searched for the knife and were unable to locate any. R13 stated R12 had threatened R13 before, but R12 did not report the incidents because R13 knew R12 did not take his medications and R13 was concerned R12 was not stable. R13 stated he had witnessed R12 not take his medications when provided, hide his medications, and offer his medications to R13 on occasions. R12's bedside tray table had a medication cup with eleven pills in the medication cup. R13 stated he thought the medication had been there since before the incident between R12 and R13. R13 stated, "I feel safer because he is not here!" R17's bed was located closest to the room door. R17's tray table had two metal spoons and a metal fork on his tray table. V20 (CNA) stated she was there when R13 reported the incident and R13's recollection was consistent with what he reported the night prior immediately after the incident. V20 stated no knife was found when the room was searched.

Final incident investigation, dated 3/1/21, shows the allegation of abuse regarding R12 toward R13 was substantiated.

Social Services Admission Note, dated 11/4/20,

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S9999	Continued From page 18 shows R12 was admitted from the hospital with "a history of mood/behaviors per hospital paperwork but has not yet displayed any negative mood/behaviors while admitted to this facility ...." The note fails to address R12's history of inappropriate sexual contact with other residents at his prior facility and fails to identify interventions to prevent resident abuse. The note also fails to identify specific interventions for R12's history of mood and behaviors to prevent abuse and fails to assess R12 for the potential of abuse related to his dementia and history of sexually inappropriate behaviors. 5. The clinical record showed R4 was admitted to the facility on 10/19/20 with a diagnosis of alcohol dependence with withdrawal, hallucinations, major depressive disorder, and malignant neoplasm of larynx and bone. Nursing note, dated 11/5/20, 11/9/20, 11/13/20, 11/14/20, 11/18/20, 11/20/20, all document R4 as experiencing anxiety, aggression, agitation, and occasional hallucinations. Nursing note, dated 11/5/20, shows R4 was having increased agitation and aggressive behaviors toward staff and staff were unable to redirect R4. The clinical record showed no new interventions implemented regarding R4's aggressive behaviors to prevent facility residents from abuse. Nursing note, dated 11/9/20, shows R4 swung his cane toward R1, R11 pushed R4, and R4 responded by poking R11 with his cane. No new interventions were identified regarding R4's aggressive behaviors to prevent facility residents from abuse.	S9999		

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Nursing notes, dated 11/13/20, shows R4 had increased anxiety, aggression, and agitation with hallucinations. R4 was throwing things inside the room, hit the nurse on duty, and attempted to hit his roommates with his cane. R4 became increasingly angry, moved back and forth in his wheelchair and did not want anyone to open his bedroom door and come inside. R4 denied access to staff who were attempting to check on R4's two other roommates. R4 "exhibited agitation and moved with force towards other resident who came in his path ...." R4 was cursing and screaming at staff and residents, blocking the Social Services door as well as pounding on the door. The note shows Social Services felt threatened by the resident because they were unable to exit their office. R4 was attempting to run over staff with his wheelchair. R4 received a dose of Haldol but R4's anxiety continued, so R4 was administered Ativan. R4's psychiatrist was contacted and an antianxiety and antipsychotic were ordered. Social services confiscated R4's cane and R4 again became "wild and threatening staff, banging door and hurting staff whenever his behavior was redirected." R4 remained verbally and physically aggressive in spite of medications administered. R4 was sent to the hospital involuntarily and the clinical record shows R4 returned from the hospital the same day with no new interventions.

Nursing note, dated 11/14/20, shows R4 was "observed with troubled and nervous behavior refusing to take all medications."

Physician note, dated 11/16/20, shows R4 was refusing to take prescribed medications. A psychotherapy evaluation was initiated; however no new interventions were implemented to

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prevent residents from abuse.

Nursing note, dated 11/18/20, shows R4 had increased agitation and aggression, episodes of on and off sudden outbursts and uncontrolled temper towards staff. R4 was prescribed an antipsychotic for seven days and staff were to monitor if R4 was compliant with taking the medication as well as the effectiveness of the medication.

Nursing note, dated 11/20/20, shows R4 attempted to elope, threatened to elope again, and refused as needed injections for agitation and anxiety. R4 also refused all medications during his shift. No new interventions were identified for R4 to protect facility residents from abuse.

Nursing notes, dated 11/25/20, shows R4 stated he was having "on and off hallucination after having a dream that he thinks it real and waking up talking to self and having a fight." R4 also stated he was having increased anxiety and depression. The notes show R4 was very agitated and aggressive, as well as verbally and physically abusive, toward staff. R4 was trying to take the stairs and refused redirection from staff. No interventions were identified in the clinical record to prevent facility residents from abuse.

Nursing note, dated 11/27/20, shows R4 was very angry, had increased anxiety, was purposefully increasing the temperature in his room to very high levels, was turning off his roommate's television, and was calling his roommate a "N_ _ _ _ _." The clinical record failed to show R4's behavior was reported to the abuse coordinator. No interventions were identified in the clinical record to prevent facility residents from abuse.

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On 2/23/21 at 3:23 PM, V2 (Acting Director of Nursing) stated no abuse investigation was initiated for the incident between R4 and his roommate on 11/27/20.

Review of facility incidents/abuse investigations fail to show an investigation was initiated for R4's 11/27/20 incident, or that the incident was reported to the abuse coordinator / administrator.

7. Initial incident/abuse investigation, dated 2/23/21, shows R12 and R13 engaged in a physical alteration. Final incident/abuse investigation, dated 3/1/21, shows the allegation of physical abuse regarding R12 was substantiated. The final investigation was submitted to the State Agency on 3/1/21.

R12 Behavioral Neurology physician note, dated 12/17/20, showed R12 had memory issues and inappropriate sexual behavior including stealing women's underwear from the laundry room of his building and presenting them to the women as gifts, would make inappropriate sexual comments toward women in his assisted living facility, and was removed from his last facility for touching another resident's breast. The note shows a similar incident happened at the facility approximately two weeks prior.

Final Incident Investigation, dated 11/18/20, shows on 11/14/20, R12 was accused by two residents of touching them inappropriately. The report concludes R8 had inconsistencies with her statements and R18 reported her allegation only when overhearing R8 report her allegation. Investigation Interview, dated 11/14/20, shows R8 was not sure at first what incident the interviewer was referring to when questioned, however R4

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provided a description and a recount of the incident once she was clear about the subject and stated the man she described was standing over her when she woke from a nap with his hand on her crotch. However, an investigation summary refers to additional information not recorded on R8's interview regarding the incident. Investigation interview with R18 showed no inconsistencies and shows R12 was accused of hugging R18 and touching R18's breast.R18 stated she then went to the nurses station to report the incident and told the nurse she wanted to speak to Social Services. The investigation fails to show R12 had a history of sexually inappropriate behaviors, was receiving Depro-Provera to treat his sexually inappropriate behaviors, and fails to show that the allegation was thoroughly investigated and other facility residents were interviewed to identify other possible victims of R12.

Facility Policy and Procedure Social Service Behavioral Monitoring, dated 10/2019, shows, "Purpose: To assure that sufficient and appropriate Social Service assessments and interventions are provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being needs for each resident. Policy: The Social Service Director will review the 24 hour Nursing Report and/or unit Behavioral Occurrence forms daily and will discuss the occurrences with the management team in the Department Head meeting to attempt to identify the root cause and need for reassessment and/or need for new intervention strategies to address the problems identified. Procedure: 1. Social Service Director or Designee will hold a daily meeting with the facility Social Service team to discuss the newly identified Mood/Behavior

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S9999	Continued From page 23 Occurrences that were identified on the 24-hour Report and/or unit Behavior Occurrence forms. 2. The team will review the medical record of each identified resident exhibiting newly identified Mood/Behavioral problems and/or exacerbation of chronic Mood/Behavioral issues to try to determine the root cause and potential need for re-assessment and the addition of new interventions to manage the dysfunctional behavioral or mood pattern. 3. The Behavioral Management Committee will review the Mood/Behavioral Occurrence with focus on the time of the occurrence; interventions initiated immediately following the identified concern, the effectiveness of the interventions and whether the mood/behavior was easily altered/safely mandated. 6. The Social Service caseworker will provide documentation within the Social service progress notes related to the occurrence and the new interventions initiated in an attempt to manage/resolve concern." Facility Policy and Procedure Close Monitoring, dated 11/8/11, shows, "Policy: To ensure that a resident is monitored close related to behaviors, falls, or a change in condition that warrants closer supervision. Procedure: 1) An IDT (Interdisciplinary Team) member indicates that a resident warrants close observation for specific reason notifies the nursing department who will then adjust schedule to have a staff member observe the resident and maintain them in their view. 2) Nurse scheduler will be notified to increase staffing to provide a staff member to oversee the resident. 3) Unit nurse will assist in giving and reassigning assistance with the resident as needed." Facility document Abuse Prevention Program, revised 1/2019, shows, "Policy: It is the policy of	S9999		

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this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. V. Identifications of Allegations/Internal Reporting Requirement - Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the administrator. In the absence of the Administrator, reporting can be made to the DON (Director of Nursing). Any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident is reported to a covered individual; covered individuals are notified annually of these reporting requirements Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the DON of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation. Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation VI. Investigation - All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. VII. Protection of Residents - Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. As part of the social history evaluation and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis. On a regular basis,.supervisors will monitor the ability of the staff to meet needs of residents." The policy fails to show that other facility residents will be interviewed for potential abuse related to an alleged abuser during an investigation.

"B"

(2 of 2)

Statement of Licensure Violations:

300.610a)
300. 1210)b
300. 1210)d)2)3)
300. 1220)b)2)
300. 3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the

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S9999	Continued From page 26 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 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: 2)All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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S9999	Continued From page 27 Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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) These requirements were not met evidencded by: Based on observation, interview, and record review, the facility failed to; 1. implement its skin-breakdown prevention care plan interventions, and follow physician orders of weekly skin check, and follow its policy on risk and skin assessment. This failure has caused multiple wounds to one (R14) of four (R14, R15, R16, and R19) residents reviewed for pressure ulcer prevention and treatment in a sample of 20 residents. Findings include: Record review on skin/wound note dated on	S9999		

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S9999	Continued From page 28 12/26/20 document that R14 was readmitted to the facility on 12/25/20 with no open skin noted. Sacrum and buttocks were intact. Record review on physician order sheet indicates weekly skin check on every Wednesday for wound prevention (ordered on 11/26/20). Record review on weekly skin assessment (electronic medical record - EMR) indicates a weekly skin assessment dated 12/31/20 with no wound noted for R14. EMR review indicates no other weekly skin assessments documented on the EMR system between 12/31/20 and 1/11/21. EMR weekly skin assessment dated 1/11/21 document loss of skin integrity with multiple wounds. Record review on weekly wound evaluation dated on 1/14/21 documented an inhouse acquired deep tissue injury with sacrum (9 x 6 x 0.1 cm), right buttocks (3.5 x 1.5 x 0 cm), left trochanter (2.5 x 1 x 0 cm), and right medial knee (1.5 x 2 x 0 cm). Weekly wound evaluation dated 2/16/21 documented in-house acquired pressure injury to the right ear (2.0 x 0.4 x 0.3 cm) Record review on hospital record dated on 2/19/21 document R14 was admitted with large stage 4 sacral decubitus, foul-smelling, older appearing packing noted in the wound with some overlying granulation tissue. On 2/26/21 at 2:10 PM, V34 (wound nurse practitioner) stated, "Deep tissue injury (DTI) is considered as pressure injury caused by prolonged pressure to body parts. The damage can be superficial to deep muscle and can deteriorate to the unstageable wound. R14 developed DTI to the right buttocks, which	S9999		

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deteriorate into an unstageable wound. She also developed DTI on the sacrum and her elbow."

On 3/3/12 at 11:55 AM, V33 (R14's attending physician) stated, "DTI develops on an immobile/bedrest patient when laying on the same position for such a long time. R14 developed DTI due to prolonged pressure on her body parts. DTI can be prevented by relieving pressure/turning/repositioning. If the facility could have followed the weekly skin check, they could have prevented wound deterioration and possibly preventing some of the wounds."

Record review on facility provided (undated) risk and skin assessment document:
II All residents will have a visual inspection of their skin.
B. Skin checks are completed weekly by the nurse.

On 2/24/21 at 4:50 PM, V16 in her office stated R15 has a low air loss mattress and a chair-cushion. V16 stated she knows he has a low air loss mattress because of his wound. Wound tech made rounds yesterday and verified all of the low air loss mattresses were in place.

On 2/24/21 at 4:55 PM in R15's room, V15 and V16 examined R15's bed and determined R15 did not have a low air loss bed in place in his room. V16 stated, "When did they change this?!" R15 replied, "I didn't work!" R15 stated he had not had his low air loss mattress for weeks since he moved into his current room from a previous room.

On 2/24/21 at 4:55 PM in R15's room, V16 examined R15 leaning to his right side in his custom wheelchair and stated, "He should not be

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S9999	Continued From page 30 sitting like that!" V16 examined both sides of R15's pressure relieving cushion and stated the right side was inflated, but the left side was deflated. V16 stated both sides should have been inflated. On 2/26/21 at 11:10 AM, observed R19 in the presence of V16 on his bed with bilateral heel-wounds and without having heel boots on. Observed heel boots left at the bedside, and R19 stated, "They didn't put it back after wound care." V16 stated, "The heel boots should have been applied to R19's foot." Record review on R19's skin care-plan indicates heel protector to bilateral heels. On 3/2/21 at 2:00 PM, V2 (Director of Nursing) stated, "Staff was supposed to follow the care plan interventions and should have applied heel boots on R19." On 2/26/21 at 2:10 PM, V34 stated, "Heel boots will help bed rest patient to prevent pressure ulcer with heels. If patients already have heel-wounds, heel boots will help to heal the wound." " B "	S9999		