

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000194	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/21/2024
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NAME OF PROVIDER OR SUPPLIER WESTSIDE REHAB & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH COLUMBIA WEST FRANKFORT, IL 62896
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S 000	Initial Comments Complaint investigation #2453514/IL172764	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240g) 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	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
05/31/24

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)</p> <p>d) 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)</p> <p>g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.</p> <p>These requirements were not met as evidenced</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>by:</p> <p>Based on interview and record review the facility failed to ensure residents are free from physical and verbal abuse for 2 of 5 residents (R26, R44) reviewed for abuse. This failure resulted in R26 experiencing incidents of mental anguish, fear, anxiety, and feeling unsafe as a result of V34's (Certified Nursing Assistant/CNA) mental and verbal abuse. The facility also failed to thoroughly and timely investigate an allegation of staff to resident abuse, and failed to prevent further abuse from occurring while allowing staff to continue to have direct care with residents after allegations were made for 4 of 5 residents (R26, R44, R46, and R300) reviewed for abuse in a sample of 14 residents.</p> <p>Findings include:</p> <p>1. R26's document titled "Admission Record" documented an admission date of 8/23/2019 with diagnoses including: Ischemic Cardiomyopathy, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Peripheral Vascular Disease, Hypertension, Hyperlipidemia, Chronic Kidney Disease stage 3, Schizoaffective Disorder, Atrial Fibrillation, Anxiety, Chronic Obstructive Pulmonary Disease, presence of Automatic (implantable) Cardiac Defibrillator, Alzheimer's Disease, Unilateral Inguinal Hernia, Diabetes Mellitus, and Unspecified Urinary Incontinence.</p> <p>R26's MDS (Minimum Data Set) dated 4/23/2024 documented a BIMS (Brief Interview for Mental Status) with score of 10, indicating moderate cognitive impairment. R26's 4/23/24 MDS section GG documented R26 required maximal assistance with toileting and hygiene; dependent</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>for shower and bathing, and lower body dressing; and partial to moderate assistance with transferring.</p> <p>R26's care plan did not document R26 having the potential for abuse.</p> <p>On 5/8/2024 at 10:32 AM, R26 was an alert and oriented resident sitting in the dining room. R26 stated his care is good here except for the night shift. R26 stated he gets his clothes ripped by a night shift CNA (Certified Nursing Assistant), V34. R26 pointed to the upper right shoulder area of his shirt that was ripped and stated V34 ripped it when he was pulling me out of bed. R26 stated, "He (V34) gets me up at 2:00 AM-3:00 AM and brings me to the dining room and I have to sit here until breakfast."</p> <p>On 5/10/2024 at 12:15 PM, R26 stated "I get tired of the treatment from (V34) CNA. I don't feel safe when (V34) is working. I want to just pull my pacemaker out and end it all sometimes, but only when (V34) is taking care of me." R26 then stated if R26 "used the bathroom in bed" V34 would roughly get R26 out of bed, ripping R26's clothes at times, and wheel R26 to the dining room to wait for breakfast. R26 stated V34 was also verbally abusive. R26 said the last time V34 had been abusive like this to R26 was within the past week of this survey (5/3/24 through 5/10/24). R26 stated facility staff were aware of V34 being abusive but "nobody does anything about it." R26 was not able to give any staff names.</p> <p>On 5/10/24 at 3:14 PM, V34 (CNA) stated he assisted R26 with care around 2:00 AM on 5/7/24, 5/8/24, 5/9/24, and 5/10/24 during bed check. V34 said R26 was usually one of the last residents V34 would assist because R26 was</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>usually not "wet." V34 said he did not like to put a "wrap around pullup" on R26 because it gave R26 an excuse to "pee in the bed" instead of using the urinal. V34 stated he was "not trying to be a d**k, but I know (R26) can use the urinal during the day." V34 said he was not trying to argue with (R26) but "If (R26) wets the bed, I make (R26) get up in his chair so I can change the bed and put a pullup on (R26)." V34 stated "(R26) was not an easy resident to care for." V34 said when he is providing care for R26, V34 "just tells (R26) like it is when things have to get done." V34 said he was "very direct" with residents and "I feel like being direct is the only way for a resident to fully understand what is about to happen."</p> <p>On 5/10/2024 at 12:30 PM, R37 a roommate of R26 stated "nightshift gets (R26) up around 3:00 AM and will make (R26) stay up if (R26) has soiled the bed. (V34 CNA) is very dismissive and verbally aggressive with (R26)." R37 stated he has heard V34 tell R26 "You must stay up because you pissed the bed." R37 said he had witnessed V34 handling R26 rough when getting R26 out of bed at night. R37 stated the last time it happened was "this past week." R37 states V1 (Administrator) knows but nothing happens. R37's 3/26/24 MDS (Minimum Data Set) documented a BIMS (Brief Interview for Mental Status) score of 15, indicating R37 was cognitively intact.</p> <p>R26's 5/15/24 final reportable incident documented in part " ... Regional Director interviewed the resident (R26) and he stated that CNA (V34) grabs his shirt pocket and rips them when he is attempting to get him out of bed. Resident stated that CNA gets him up at 2 or 3 AM for no reason ... Resident state that CNA talks rudely to him ... Regional Director interviewed</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>(R26's) roommate (R37). (R37) is (alert and oriented times 4). (R37) stated that (R26) is pulled around by (V34) in the middle of the night because resident doesn't want to get up at 2 AM. (R37) stated that (V34) is verbally demeaning to resident and his tone of voice is aggressive when speaking with (R26) ... Conclusion.. After a thorough investigation the facility is able to substantiate the allegation. (V34) has been terminated ..."</p> <p>2. R44's face sheet documented an initial admission date of 6/30/23 with diagnoses including, aftercare following joint replacement surgery, paranoid schizophrenia, conversion disorder with seizures or convulsions, gout, hypertension, schizoaffective disorder bipolar type, anxiety disorder, and hyperlipidemia.</p> <p>R44's 3/8/24 MDS documented a BIMS score of 00, indicating severe cognitive impairment. R44's 3/8/24 MDS section GG documented R44 was dependent for all Activities of Daily Living (ADL) except eating. R44's care plan did not document R44 was at risk for abuse.</p> <p>On 5/10/2024 at 12:20 PM, R44 was interviewed but was a poor historian with some confusion noted.</p> <p>On 5/10/24 at 3:14 PM, V34 (CNA) said he recalled when R44 returned to the facility from the hospital because "it was a sad time" because R44 "was very sick." V34 said after answering R44's call light one night, V34 had gotten about halfway back down the hall after answering R44's call light when R44 turned his call light on again. V34 said he had joked with R44 saying "what do you need now? It's been 5 seconds since I left."</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>V34 said there were times R44 has been "half awake" and V34 did not know if R44 knew he was joking. V34 said staff will get frustrated with R44 using the call light. V34 said R44 was a very confrontational resident. V34 said he had gotten frustrated with R44 in the past when R44 would not use the urinal. V34 said when R44's urinal is empty, V34 has told R44 that V34 knows no staff have emptied R44's urinal and R44 needs to start using it. V34 said he was not sure if V34 telling R44 to use the urinal would be taken as threatening "because we have to tell (R44) that every night."</p> <p>On 5/10/24 at 12:15 PM, V37 (CNA) said he had worked in the facility for about 7 months. V37 said he had never witnessed any physical abuse while in the facility but had witnessed verbal abuse. V37 said R44 had just returned from the hospital and there was something wrong with R44's stomach. V37 said R44 kept turning on the call light thinking R44 had to use the restroom but when staff would get to R44's room R44 would say he didn't have to go anymore. V37 said he witnessed V34 (CNA) say to R44 that V34 was going to take R44's call light away from R44 if R44 did not stop turning the call light on. V37 said he did not report the incident because he wanted to give V34 a chance, but it didn't do any good. V37 said he knew what V34 had done to R44 was abuse. V37 said V34 could be rough with residents during care.</p> <p>R44's 5/14/2024 Incident Investigation Form documented an interview by V37 (CNA) " ...(R44) was on the light quite a bit thinking he had pooped. He had been on the call light a lot. (V34 CNA) told (R44) "if you didn't s**t, I'm going to take that call light away from you." ... Didn't report because (V37) was busy and didn't want to see</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>(V34) get in trouble..."</p> <p>On 5/14/24 at 12:57 PM, V44 (Regional Director of Operations) said that she had forgotten about R44's abuse allegation on 5/10/24. V44 said she would have R44's investigation completed on that day (5/14/24).</p> <p>On 5/14/24 at 4:00 PM, V44 (Regional Director of Operations) presented R44's 5/4/24 facility investigation and verified the one staff interview of V37 (CNA) was the complete investigation. R44's 5/14/24 facility investigation file did not contain any other staff interviews or resident interviews.</p> <p>On 5/15/2024 at 2:10 PM, V1 (Administrator) stated the staff she usually interviews are the supervisors and/or directors. V1 stated she usually only interviews the staff that are around. V1 stated "I only interview the residents that are alert and oriented."</p> <p>R44's 5/15/24 final reportable to Illinois Department of Public Health (IDPH) documented in part " ... Summary ... it was reported to (V44 Regional Director of Operations) by (V37 CNA) that at an unknown date and time (R44) had recently returned from the hospital and was on his call light quite a bit. (V34 CNA) came into work at 6pm and (R44) had been continually putting on his call light thinking that he had had a (bowel movement) but had not. (V37) stated that one time when the call light went off he went to answer it and (V34) went with him. (V37) then stated that (R34) told (R44) if you have not s**t I'm taking the call light away for the rest of the night ... Conclusion ... After a thorough investigation the facility is able to substantiate the allegation. (V34) has been terminated ..."</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>On 5/8/24 at 10:55 AM, V19 (CNA) said she worked day shift in the facility. V19 said she had heard a resident say the "guys" on midnight shift are "mean." V19 said V34 (CNA) was related to someone who used to be in management at the facility.</p> <p>On 5/8/24 at 1:16 PM, V42 (Licensed Practical Nurse/ LPN) said on 5/4/24 she had reported other allegations to V1 (Administrator) regarding V34 (CNA) as being physically and verbally abusive. V42 said (V34 CNA) was related to someone who used to be in management at the facility. V42 said she had "heard some things about V34 being rough" but had never witnessed any abuse by V34 herself.</p> <p>On 5/13/2024 at 4:25 PM, via phone interview V12 CNA (Certified Nurse Assistant) stated she has received training on abuse but, unsure of last time. I have never seen abuse, but I have been told that midnight CNAs call resident's names, names that are not nice, and the main one that does this is R34. V12 stated" I know he tells R44 not to push his f**king call light anymore." I didn't witness this but was told about it, so I didn't report it. V12 states she has never been questioned or part of an investigation for abuse.</p> <p>On 5/14/2024 at 4:20pm, V44 (Regional Director of Operations) stated the investigations were completed for the allegations of abuse on both R26 and R44 and both investigations substantiated that abuse occurred. V44 stated she terminated V34 on this date.</p> <p>Document titled "Abuse Prevention Program" with Revised date of 11/28/2016 documented in part " ...this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>resident property and exploitation ..."</p> <p>3. Document titled "Admission Record" documented R300 admission date as 4/5/2024 with diagnoses including Intervertebral Disc Degeneration, Thoracic Region, Polyarthritis, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, Anemia, Vitamin D Deficiency, Hypertension, Mild cognitive impairment.</p> <p>R300's Minimum Data Set (MDS) dated 4/15/24 documents a BIMS (Brief Interview for Mental Status) score of 13, which indicates R300 is cognitively Intact.</p> <p>On 5/8/2024 at 9:59 AM, R300 was alert and oriented stated, "I know why you are here so I will explain what happened to me. On the night that I was admitted (4/5/2024) I just wanted to go back to live in my car or go live with my grandson that lives her in (town of facility)." R300 stated "I was walking outside of the building when V34 CNA (Certified Nursing Assistant) grabbed me around the waist, tackled me from behind, and drug me to the ground face first. I didn't see anyone else outside, but I thought I heard someone say, get him." R300 stated "I have a bad back from a vehicle wreck that happened years ago, and this just made the pain worsen. My pain has increased since this occurred." R300 stated he told people about being tackled but wasn't sure of their name as he was new in the facility or the time he reported it. R300 stated "I do not feel safe, and I have to sleep lightly because V34 is always in my room taking care of my roommate." R300 then stated, "I am afraid that V34 will come in here with a club and hit me in the head."</p> <p>On 5/10/2024 at 11:20 AM, V38 PRSC</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>(Psychiatric Rehabilitation Service Counselor) stated R300 came to her on Friday evening (5/3/2024) and reported his allegation of physical abuse. V38 stated R300 came to her and told her when he was out front a guy came up and wrapped his arms around R300 and threw R300 down. V38 stated "I just didn't think it happened on dayshift." V38 said R300 described the guy that allegedly did this was "Mexican" and the facility did not have anyone employed that fit that description. V38 stated "the way it was brought to me by (R300) didn't give me all the details. He was just looking for the guy that threw him on the concrete." V38 stated she didn't report this to V1 (Administrator) until the following Monday (5/6/2024) and V1 came in and asked V38 for a grievance form. When V38 was questioned about abuse training, V38 stated "abuse is to be reported immediately to the administrator." V38 also stated she knew what an allegation of abuse was and assists in training facility staff with abuse training.</p> <p>On 5/10/2024 at 10:58 AM, V6 SSD (Social Service Director) stated on 5/7/2024 R300 came and told her he knew the name of the guy that tackled him in front of the building, and it was V34 (CNA). V6 stated she asked him what he was talking about and V6 stated she was unaware of any situation like that.</p> <p>On 5/7/24 at 9:10 AM, V1 (Administrator) said R300 had reported the allegation of abuse to V6 (Social Services Director) on the evening of 5/6/24.</p> <p>On 5/15/2024 at 2:10 PM, V1 (Administrator) stated she questioned V34 (CNA) on the allegation involving R300 but was unsure of the date and time. V1 then stated she interviewed</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>V34 on 5/10/2024 and V34 was suspended at that time.</p> <p>On 5/10/24 at 3:14 PM, V34 (CNA) said he was never questioned about R300's allegations. V34 said he was not aware there was any suspicion he was the alleged perpetrator. V34 said he had worked in the facility on 5/6/24, 5/7/24, 5/8/24, and 5/9/24. V34 said he was not suspended related to R300's abuse allegations prior to 5/10/24.</p> <p>V34's undated facility timecard provided by the facility on 5/10/24 documented V34 was working in the facility on 5/3/24 from 5:54 PM to 5/4/24 at 6:03 AM, 5/6/24 from 9:56 PM to 5/7/24 at 6:03 AM, 5/7/24 from 9:55 PM to 5/8/24 at 6:05 AM, 5/8/24 from 9:56 PM to 5/9/24 at 6:11 AM, and 5/9/24 from 9:54 PM to 6:01 AM.</p> <p>On 5/13/2024 at 4:25 PM, via phone interview V12 (CNA) stated, "I heard V34 shoved R300 down to the ground." V12 said she did not witness V34 shove R300 but have heard about in the facility. V12 stated she works 6:30 AM to 2:00 PM shift. V12 stated "I have been told that V34 will call R6 a "fat a** and lazy a**" the CNA that says these things is V34.</p> <p>On 5/17/24 at, 2:50 PM, V44 (Regional Director of Operations) said she expected staff to be suspended pending an investigation. V44 said she expected V34 (CNA) to have been suspended on 5/6/2024. V44 said she expects all staff to be interviewed in an abuse allegation investigation.</p> <p>On 5/10/2024 at 1:00 PM, R300's investigation file was reviewed and noted initial time of staff acknowledgment was on 5/3/2024, but</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER WESTSIDE REHAB & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH COLUMBIA WEST FRANKFORT, IL 62896
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S9999	<p>Continued From page 12</p> <p>investigation was not started until 5/6/2024. V34 was the perpetrator named by R300 and no statement or interview was completed by V34. V34 was allowed to work on 5/3/2024, 5/6/2024/, 5/7/2024/ 5/8/2024 and 5/9/2024. V34 was interviewed on 5/10/2024 and at this time V34 was included in R300's facility investigation.</p> <p>4. 4. R46's face sheet documented an initial admission date of 8/24/23 with diagnoses including: pulmonary hypertension, chronic obstructive pulmonary disease, post- traumatic stress disorder, attention- deficit hyperactivity disorder, hypothyroidism, anxiety disorder, depression, borderline personality disorder, mild intellectual disabilities, need for assistance with personal care.</p> <p>R46's 2/28/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R46 was cognitively intact.</p> <p>On 5/8/24 at 9:56 AM, R46 said a CNA told him to turn his "f**king" music down. R46 said he (V34/CNA) was always complaining about R46's music. R46 said he has not had any problems with any other staff. R46 said this incident happened on 5/3/24. R46 said the next day (5/4/24) V1 (Administrator) came to speak with R46. R46 said V1 had told him that V34 had never cussed at him, and the incident didn't happen. R46 said V1 told him that V1 did not believe him. R46 said he did not feel safe when V34 was working. R46 said he had not told V1 he did not feel safe while V34 was working because V1 had never asked.</p> <p>On 5/8/24 at 12:26 PM, V40 (Housekeeper) said she reported that R46 had made an abuse</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>allegation to her on 5/4/24. V40 said R46 had made an allegation V34 (Certified Nursing Assistant/ CNA) had cussed R46 out in the dining room on 5/3/24 due to R46's tablet being too loud. V40 said she had reported R46's abuse allegation to V42 (Licensed Practical Nurse/ LPN) and had given V42 a written statement.</p> <p>On 5/8/24 at 1:16 PM, V42 (LPN) said on 5/4/24 V40 (Housekeeper) had reported an abuse allegation pertaining to R46. V42 said she asked V40 to complete a written statement and called V1 (Administrator) to report the abuse allegation. V42 said there were 2 abuse allegations reported to her very close together on 5/4/24 and V42 had reported both to V1 via telephone. V42 said she went to speak with R46 on 5/4/24 and R46 reported V34 (CNA) on midnight shift had cussed at him over R46's music being too loud.</p> <p>On 5/8/24 at 2:20 PM, V1 produced written statements by staff pertaining to R46's abuse allegation. A 5/4/24 Nurses Note written and signed by V40 (Housekeeper) documented in part " ... (R46) told me this morning that a black haired CNA cussed him out and was yelling at him over his TV being to (sic) loud. I said are you talking about (V34) and he said yes. I told him to tell the nurse about it ..." Another 5/4/24 Nurses Notes written and signed by V42 (LPN) documented in part " ... This nurse asked resident (R46) what happened in the middle of the night, (R46) said that he was cussed out by (V34) (R46) said that (V34) told him to "turn the f**king music down."</p> <p>On 5/8/24 at 2:20 PM, V1 (Administrator) said R46's abuse allegation was not substantiated so V1 did not feel the allegation needed to be reported. V1 presented R46's 5/4/24 facility investigation documents with all persons</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>questioned. R46's 5/4/24 facility investigation file documented only staff were interviewed but no residents were interviewed. On 5/15/2024 at 2:10 PM, V1 (Administrator) stated "I feel like our standard investigations are good." V1 stated "yes we do notify the physicians when there is an abuse allegation."</p> <p>On 5/15/2024 at 1:53 PM, this surveyor received a return call from V33 (Physician). V33 stated he was not notified of allegation of abuse on R300 or R26. V33 stated he was not aware of any of this, but he ordered x rays for R300 because of increased pain but thought it was from old injuries from an accident. V33 stated he changed R300's pain medication because he knew that the pain medication (tramadol) was a medication that the resident was on for a long time. V33 stated he changed R300's pain medications to help reduce the pain that he knew was a chronic issue.</p> <p>On 5/15/2024 at 2:10 PM, V1 (Administrator) stated on Monday morning (5/6/2024) V38 (PRSC) reported an allegation of abuse to R300. V1 stated she instructed V6 (Social Services Director) to go talk to R300. V1 stated the staff she usually interviews are the supervisors and/or directors. V1 stated she usually interviews the staff that are around. V1 stated "I only interview the residents that are alert and oriented." While V1 was being questioned about the investigation procedure of an abuse allegation by a resident V1 stated "sometimes it is the resident's fault." When V1 was asked to clarify what she meant by "sometimes it is the resident's fault" V1 said "yeah" and turned her chair around at her desk and started going to through papers and refused to say any more.</p> <p>On 5/13/2024 at 3:23 PM, via phone interview</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>V43 (housekeeper) stated she has worked for 4 and a half years at the facility. V43 stated "I have never received abuse training and has never been questioned about any abuse investigations." V43 stated she has witnessed verbal abuse on several occasions in the past by CNA's and Nurses' especially loudly in the hallway. V34 states "I recently took family leave and was off about a month." V43 stated "I think you need to go talk to the residents and see if they tell you anything". V43 stated she didn't report because everyone hears it.</p> <p>The facility's undated census list provided on 5/7/24 documented 47 residents residing in the facility.</p> <p>Document titled "Abuse Prevention Program" with Revised date of 11/28/2016 documented in part " ...Upon learning of the report, the administrator or designee shall initiate an investigation. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions ... V. Protection of Residents ... The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property while the investigation is underway ... employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee ..."</p> <p>(B)</p>	S9999		