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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/22/2024 |
| NAME OF PROVIDER OR SUPPLIER Irving Park Living & Rehab Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 4340 North Keystone Chicago, IL 60641 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49783</p> <p>Based on the interview and record review, the facility failed to thoroughly and timely investigate a situation of potential staff-to-resident abuse for one resident (R1) reviewed for physical abuse in the sample of three.</p> <p>Findings include:</p> <p>On 8/20/2024 at 2:00 PM, V3 stated I got a call from the R1 family, and she reported that V5 struck R1 in the penis on 8/6/2024 while giving patient care, and nothing was being done. She also informed me the facility has not started working on R1 discharge planning. After speaking with the family, I immediately came out to visit R1 and informed the facility Administrator on 8/15/2024.</p> <p>On 8/20/2024 at 11:36 AM, R1 states on the evening of 8/6/2024, the CNA(V5) came to my room. I pulled the call light because I needed to be changed. I told the CNA I think I had a bowel movement. The CNA came over to check to see if I was wet and struck me in my private area, and I yelled. I was yelling because I didn't understand why he would check me like that, and I have a urinary catheter that caused me so much pain. V6 came in, and I informed her and told her I didn't want V5 taking care of me anymore. He was very rough with me. I called my sister and told her that night.</p> <p>On 8/21/2024 at 11:17 AM V1(Administrator)states, initially this was reported as a concern on the 8/6/2024 that V5 touched the catheter which caused pain and V5 did not know he had catheter. V6 reported to ADON. ADON spoke to V2 and there was a concerned filled out for patient care. Staff made sure V5 was not scheduled to work that set. R1 reported to the nurse that everything was okay. On 8/15/2024, the ombudsman came in and reported to me that the family called and informed him that he was struck by [NAME] while giving patient care. I interviewed R1, and he showed me how he was checking his diaper, and he was touching the catheter, and that it hurt, and he didn't want [NAME] taking care of him. He reports [NAME] struck him while checking to see if he was dry. The resident reported he allowed [NAME] to change him. I immediately started my investigation and reported that to IDPH.V5 was suspended until further investigation. Final was sent this Monday 8/19/2024 to IDPH and completed full investigation 8/16/2024. All staff, clinical or non-clinical, should report any allegations of abuse.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 8/21/2024 at 9:20 AM V2 states, V9 informed me that R1 family called 8/7/2024 and reported V5 was rough with this resident during patient care on 8/6/2024. At the time, we viewed this as a concern and made sure V5 was no longer assigned to take care of R1.V5 also completed an in-service. On 8/15/2024, the ombudsman notified my administrator that the family had called in to report that V5 had struck R1 in the groin area. If a resident informs the nurse that a staff member is being rough or reports any abuse, this should be reported immediately to the administrator.</p> <p>On 8/21/2024 at 11:39 AM, V9(ADON) states, I found out about the incident from V8 (Family). She called in the late afternoon of 8/7/2024 to speak to a supervisor, so the call was directed to me. V8 was yelling on the phone and screaming at me stating she didn't want V5 taking care of R1 and she wanted her brother discharged . She reported that V5 was rough with her brother. I asked the family to explain exactly what R1 reported to her. V8 really didn't want to speak with me. She wanted to speak to the administrator. She did not report that R1 was struck, kicked or hit by V5. I thought this happened that same day, so I went down to the second floor to see R1 and V5. I saw V5 in dining area feeding residents and I ask what happened the night before with the R1. The sister just called and reported you were being rough with the resident. V5 reported it happened yesterday. He was trying to see if R1 had a bowel movement. He saw call light on, and he went to check him V5 reported he was unaware R1 had a foley catheter in so he took off brief the resident yelled that hurt and I have a catheter why would I be wet. R1 reported to V6 that he was being rough with him.</p> <p>No documentation in the medical record regarding the allegations reported dated 8/6/2024.</p> <p>Reviewed 24-hour incident investigation report started 8/15/2024.</p> <p>Reviewed final report dated 8/19/2024.</p> <p>Facility policy date 10/22/2024 titled Abuse Prevention Policy documents in part, section V, employees are to report any incident, allegation or suspicious of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe hear about, or suspect to the administrator immediately.</p> | | |