

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Landmark of Richton Park Rehab & Nsg Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 22660 South Cicero Avenue Richton Park, IL 60471	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to treat one resident with respect and dignity by placing him in the hallway tied to a wheelchair and having pictures taken. This failure affected one of one resident (R5) reviewed for dignity. Using the reasonable person concept it is reasonable to conclude that R5 felt cold, uncomfortable, and dehumanized when he was sitting in a wheelchair, in the hallway, with a sheet, no shoes, no socks.</p> <p>The findings include:</p> <p>On 8/29/23 an image of identified resident R5 obtained. Image is of a male, with disheveled, long, black hair, and long facial hair. R5 sitting in a room, in a wheelchair, no socks or shoes, in a hospital issued gown, with a face mask on, below his chin. A second image of a male, dark skinned, sitting in a wheelchair, in the hallway, leaning forward, back exposed, no hospital gown is seen in the picture. R5 appears to be covering his face or head with a white sheet. Image matches with the identified hallway of the facility hallway, outside of the elevator to the left, in front of the dining room door, below sprinkler device. R5 sitting across from nurses' station desk with the back of the computer monitor. The floor pattern and wallpaper match to the facility decor. No face for the resident is visible and his feet are exposed, no shoes or socks. Additionally, the picture shows R5 tied with a white sheet to the wheelchair and two knots in the back. A gait belt is visible around the back of the wheelchair. A blue scrub pant is visible in the lower corner of the image. A camera is observed in the vicinity directly in the line of sight where the resident in the picture is sitting.</p> <p>R5 is [AGE] years old with diagnosis including, but not limited to Convulsions, Alcohol Abuse with Alcohol Induced Anxiety Disorder, Depressive Episodes, Schizoaffective Disorder, Dementia, Acute Cystitis, and Bacterial Pneumonia. R5 was admitted to the facility on [DATE] around 2:00PM - 2:30PM (per DON). At 6:02PM R5 was ordered a psychiatric transfer, and transferred to the hospital on 7/27/24 at 12:25AM. R5 was admitted to the hospital.</p> <p>On 9/10/24 at 9:46AM V24, CNA, said V19 told her was going to take pictures of the situation with R5. V24 said I didn't report it because I wasn't in the facility.</p> <p>On 9/10/24 at 10:40AM V18, Scheduler said she heard V19 talking about R5 on the phone and say I'm going to take pictures and send them. V19 said staff taking pictures of resident is a HIPPA violation.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 8/30/24 at 12:29PM V5, DON, said she had seen V19 on his phone while on duty and told him to get off the phone. V5 said another staff heard V19 talking on the phone about R5. V19 said talking about the patient to someone else is a HIPPA violation.</p> <p>On 9/3/24 at 3:20PM V5, DON, said V18 called me and told me V19 was on the phone talking to someone about R5 and about how bad he is and something about pictures. V5 said, V18 and V24 should have reported V19.</p> <p>On 9/10/24 at 12:07PM V25, Administrator, said V19 probably should not have completed the shift on 7/26/24. V25 said if I had been there, V19 would not have been allowed to return to the floor after walking out. V25 said I did not know anything occurred with R5 until V5 spoke with me after she spoke with the surveyor.</p> <p>On 9/12/24 at 11:50AM V26, Infection Preventionist, said when a resident comes out of the room, to a common area they should have clothing on, no gown, be clean, face washed, and have their walker or wheelchair. V26 said for footwear we use non skid socks if they don't have shoes or slippers. V26 said we can use donated clothing from laundry that they can wear, or we can double gown to cover their front and back. V26 said we would double gown to give them some privacy. V26 said if they are out in a common area not dressed or with a their back exposed they could most definitely feel uncomfortable and maybe a little cold.</p> <p>The facility abuse prevention dated 1/2019 states during orientation of new employees the facility will cover the following topics sensitivity of resident rights and resident needs, staff obligations to prevent and report abuse, neglect, exploitation, mistreatment, any kind of crime against the resident, theft and how to distinguish theft from lost items and willful abuse from insensitive staff actions. Dementia management and resident abuse prevention. What constitutes abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. This prohibitions against taking, using, keeping, distributing photographs, recording of residents. The facility desires to prevent abuse, neglect, exploitation, misappropriation, and a crime against a resident by establishing a resident sensitive and resident secure environment.</p> <p>Staff taking or using a photograph or recording of a resident in a manner that demeans or humiliate a resident, regardless of the residents cognitive status, is strictly prohibited and will be handled as an allegation of abuse.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to follow their abuse policy to prevent unauthorized photos of a resident restrained to a wheel chair in the hallway. This affected one of three residents R5 reviewed for mental abuse. This failure resulted in R5 having unauthorized photos taken of him restrained to a wheelchair which is demeaning, and humiliating.</p> <p>Findings include:</p> <p>On 8/29/24 at 11:21AM V19, Certified Nursing Assistant (CNA), said on 7/26/24 I saw R5 had a gait belt around him. V19 said I was assigned to be R5's one to one, monitoring him. V19 said I talked to V11, LPN, and V5, DON, and the scheduler. V19 said I told V5 about the gait belt around R5 before she left like at 4:30PM. V19 said they said if you don't want to watch the patient, then go home. V19 said I left the floor and then I came back up to the floor around 6:00PM or 7:00PM and R5 had the sheet around him. V19 said I got fired because of this. V19 said I saw R5 with the sheet tied with two knots around his stomach and he was sitting on a regular wheelchair, he also had the gait belt on. V19 said I documented it, V19 provided pictures to IDPH from his personal phone.</p> <p>On 8/29/23 an image of identified resident R5 obtained. Image is of a male, with disheveled, long, black hair, and long facial hair. R5 sitting in a room, in a wheelchair, no socks or shoes, in a hospital issued gown, with a face mask on, below his chin. A second image of a male, dark skinned, sitting in a wheelchair, leaning forward, back exposed, no hospital gown is seen in the picture. Image matches with the identified hallway of the facility hallway, outside of the elevator to the left, in front of the dining room door, below sprinkler device. R5 sitting across from nurses' station desk with the back of the computer monitor. The floor pattern and wallpaper match to the facility decor. No face for the resident is visible and his feet are exposed, no shoes or socks. A blue scrub pant is visible in the lower corner of the image. A camera is observed in the vicinity directly in the line of sight where the resident in the picture is sitting.</p> <p>R5 is [AGE] years old with diagnosis including, but not limited to Convulsions, Alcohol Abuse with Alcohol Induced Anxiety Disorder, Depressive Episodes, Schizoaffective Disorder, Dementia, Acute Cystitis, and Bacterial Pneumonia. R5 was admitted to the facility on [DATE] around 2:00PM - 2:30PM (per DON). At 6:02PM R5 was ordered a psychiatric transfer, and transferred to the hospital on 7/27/24 at 12:25AM. R5 was admitted to the hospital.</p> <p>On 9/10/24 at 9:46AM V24, CNA, said on 7/26/24 around 5:00PM - 5:30PM I was at home when V19 called me, he said they stuck him with a one to one monitor. V24 said V19 said they were restraining the resident. V24 said V19 was going to document by taking pictures. V24 said I don't think V19 took pictures of R5's face, just the restraint. V24 said I didn't report to anyone because I felt V19 had it under control and I didn't see it because I wasn't in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 9/10/24 at 10:40AM V18, Scheduler, said I heard V19 on the phone when I was walking in the hallway, after dinner between 5:15-5:30. V18 said I heard V19 telling someone, this resident he doesn't sit down, he is getting on my nerves. V18 said I don't know who V19 was talking to. V18 said I asked V19 if he was taking pictures and he said no he was not. V18 said I told V5 I heard V19 say I'm going to take pictures and send them. V19 said V24 mentioned V19 told her he was going to send the pictures. V18 said I told V19 you can't take pictures. V18 said I didn't see V19 take pictures. The surveyor asked V18 do you have to see abuse happen to report it? V18 said no. V18 said I felt I needed to call V5 to see if V19 needed to be sent home, because he was on the phone. V18 said V19 stayed with R5 until the end of his shift. V18 said staff are not allowed to take pictures of the residents because it is a HIPPA (Health Insurance Portability and Accountability Act) violation. V18 said staff are not supposed to be on the phone while on duty with a resident. V18 said staff are not to be on the phone while assigned one to one monitoring with residents.</p> <p>On 8/30/24 at 12:29PM V5, Director of Nursing, said V19 was terminated for being on his cell phone, twice. V5 said on 7/26/24 I told him to get off the phone when I saw him. V5 said another staff observed V19 on the cell phone and heard V19 talking about R5 and how bad R5 was and R5 did not need to be here. V5 said that same night V19 was mad and said he was leaving, he was upset about having to do the one to one. V5 said when I spoke to V18 by phone, it may have been 9:00PM or 10:00PM. V5 said V19 did not finish his shift, we got someone else to monitor R5. V5 said taking resident pictures is a HIPPA violation. V5 said I told V18 to take V19 off the schedule until I speak with him on Monday.</p> <p>On 9/3/24 at 3:20PM V5, said V18, Scheduler, called me while I was at home and said when she walked in R5's room and saw V19 on the phone. V5 said V18 reported V19 was on the phone talking to someone about how bad R5 is and something about pictures. V5 said V18 said she asked V19 if he was taking pictures. V5 said V19 was the only CNA assigned to R5. V5 said after the surveyor spoke with me (on 8/30/24) I spoke with my staff and V24 said V19 called me and said he was going to take pictures of the resident. V5 said V24 said she didn't report it because it didn't involve me and she didn't want to get involved. V5 said V18 and V24 should have both reported V19 on 7/26/24.</p> <p>On 9/10/24 at 12:07PM V25, Administrator, said V19 probably should not have completed the shift on 7/26/24. V25 said V19 talking about R5 on the phone violates policy. V25 said if I had been there, V19 would not have been allowed to return to the floor after walking out. V25 said I did not know anything occurred with R5 until V5 spoke with me after she spoke with the surveyor.</p> <p>V19 employee file notes his hire date is 7/10/24. Review of V19's employee file conducted. V19's HIPPA Quiz dated 7/10/24 has no responses for the questions. On 7/10/24 V19 signed I acknowledge that I have received and read the facilities abuse prevention program policy and procedure. I have received and read the social media policy. I understand the requirements of the social media policy represents the standards and policies of the facility.</p> <p>The facility provided two Personnel Change Forms for V19, both dated 7/29/24. One notes termination is voluntary Employee left on his own accord. Last day worked 7/29/24. The second form notes termination is Involuntary violation of facility policy. No last day worked is noted.</p> <p>IDPH received three pictures of R5 on 8/29/24 at 11:49AM. The last time V19 worked with R5 was on 7/26/24. R5 retained the pictures in his phone for 34 days.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The facility abuse prevention program policy and procedure dated 1/2019 states during orientation of new employees the facility will cover at least the following topics prohibitions against taking, using, keeping, or distributing photographs, recordings of residents or a resident's personal space, as described in section below. The facility defined mental abuse includes taking or using photographs or recordings in any manner that would demean or humiliate the resident. This includes taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (cameras, smart phones, and other electronic) devices and/or keeping or distributing them through multimedia messages or on social media networks.</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to ensure one resident was not physically restrained by being tied into a wheelchair with a gait belt and a bed sheet. This failure affects one of three residents (R5) reviewed for restraint use. This failure resulted in R5 having his freedom of movement inhibited and ongoing agitation, aggression, and anxiety. It is reasonable to conclude that R5 felt embarrassed and dehumanized.</p> <p>The findings include:</p> <p>On 8/29/24 at 11:21AM V19, Certified Nursing Assistant (CNA), said on 7/26/24 R5 was on one to one monitoring, he was a lunatic. V19 said R5 was trying to throw himself on the floor. V19 said I saw R5 had a gait belt around him and I told them, I don't feel comfortable with the belt on him. V19 said I talked to V11, LPN, and V5, DON, and the scheduler. V19 said I told V5 about the gait belt around R5, before she left like at 4:30PM. V19 said I didn't say anything about the sheet. V19 said they said if you don't want to watch the patient, then go home. V19 said I left the floor and then I came back up to the floor around 6:00PM or 7:00PM and R5 had the sheet around him. V19 said I got fired because of this. V19 said I saw R5 with the sheet tied with two knots around his stomach and he was sitting on a regular wheelchair, he also had the gait belt on. V19 said I documented it, V19 provided documentation to IDPH.</p> <p>R5 is [AGE] years old with diagnosis including, but not limited to Convulsions, Alcohol Abuse with Alcohol Induced Anxiety Disorder, Depressive Episodes, Schizoaffective Disorder, Dementia, Acute Cystitis, and Bacterial Pneumonia. R5 was admitted to the facility on [DATE] around 2:00PM - 2:30PM (per DON). At 6:02PM R5 was ordered a psychiatric transfer, and transferred to the hospital on 7/27/24 at 12:25AM. R5 was admitted to the hospital.</p> <p>On 8/29/24 at 1:18PM V10, Registered Nurse (RN), said I did the admission for R5. V10 said R5 was a little aggressive and he was not verbal. V10 said when I spoke with R5 he understands a little and was alert times 1-2. V10 said R5 was not mobile, he was not steady, he liked to grab at people. V10 said R5 was a complete assist, he needs staff assistance for everything. V10 said R5 was a fall risk. V10 said I had to call for someone to sit with him. V10 said R5 was constantly trying to get up and he was aggressive. V10 said R5 sat in a regular wheelchair. V10 said we got a sitter for him in the evening. V10 gave a description of R5, she said he was an African American male, about 110 pounds, 5'3 - 5'2, thin, and he had a gastric tube when he first came to us. V10 described R5's hair as not well kept and he had a thin beard. V10 was shown a picture of a male, sitting in a chair, in a room and V10 said that is him identifying R5.</p> <p>On 8/29/24 1:33PM V11, Licensed Practical Nurse (LPN), said we needed a one to one for R5. V11 said R5 had behaviors. V11 said R5 would throw things at staff, use verbal profanity, and he would not stay seated for 2 seconds. V11 said the assigned monitors reported R5 was hitting them and he would urinate wherever he was. V11 said R5 sat in a wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 8/29/24 at 2:25PM V14, CNA, said I used to take R5 outside to try and calm him down, in a wheelchair. V14 said I know V19, CNA, was assigned as one to one monitor for R5 on 7/26/24. V14 said I saw V19 standing outside of R5's room, and not in the room like he should have been. V14 said at one point, R5 was brought out to the nurses station, he was in a gown, in a wheelchair. V14 said R5 was always trying to stand up. V14 said I had seen R5 leave urine on the floor.</p> <p>On 8/30/24 at 10:09AM V16, CNA, said on 7/26/24 V19 got pulled to monitor R5. V16 said R5 was really anxious, he tried to get up, and his legs go weak. V16 said we kept coming back to check on V19 because R5 was anxious, he was in the wheelchair rolling everywhere. V16 said at first V19 was nervous with R5, I had to pull him out the room and talk to V19 about how to address R5's behavior. V16 said R5 and V19 were in the hallway and in the room. V16 said I think V19 had blue scrubs on that day. V16 said V19 said R5 was throwing feces. V16 said R5 was in a wheelchair. V16 said V19 was having a panic attack after R5 was throwing feces and urinating. V16 said V19 came to the nurses' station, and he said this is too much, I can't deal with this and R5 was in the room. V16 said I told V19 you need relief for a one to one. V16 said V19 was belligerent, he was not listening and having a panic attack, and V19 went down the stairwell. V16 said V19 ended up coming back to the floor, he was gone like 10 minutes. V16 said V19 was doing this around 5:30PM, mealtime. V16 said R5 had tried to throw himself out of the chair or lean forward. V16 said V18, Scheduler, tried to do education with V19 about how to care for R5. V16 said the shift ends at 11:00PM, and V19 sat with R5 until 11:00PM.</p> <p>On 8/30/24 11:10AM V5, Director of Nursing (DON), said we issue gait belts to the CNAs and we expect them to use them for transfers. V5 said they have the gait belts on them, they are expected to carry them while at work. V5 said R5 was all over the place he kept getting up from his wheelchair. V5 said we assigned a one to one monitor because we were afraid R5 was going to fall. V5 said R5 was standing, difficult to redirect, pulling at his gastric-tube, reaching and grabbing for the CNAs. V5 said we got a wheelchair for R5 and sat him at the nurses' station because he kept trying to stand. V5 said V19 was pulled to monitor R5. V5 said R5 was at risk for falls, not redirectable, not listening, and not interested in anything. At 12:29 V5 said V19 was terminated for being on his cell phone twice on 7/26/24 while he was assigned the one to one with R5. V5 said a CNA observed V19 on the cell phone, and heard him talking about R5 and how bad he was and he did not need to be here. V19 said that same shift V19 said he was mad and he was leaving. V5 said V19 was upset about having to do the one to one. V5 said a physical restraint would be to tie a resident down in bed or a chair using a gait belt or a sheet. V5 said a restraint would be anything used to keep a resident from getting up. The surveyor asked V5 does a restraint inhibit freedom of movement, can it cause anxiety, agitation, and aggression? V5 responded yes to all. V5 said the use of physical restraint is considered abuse.</p> <p>9/10/24 9:46AM V24, CNA, said I was at home when V19 called me on 7/26/24. V24 said V19 said they stuck him with a one to one. V24 said V19 said they were restraining R5. V24 said V19 said that R5 was restrained to a chair. V24 said it was around 5:00-5:30PM when V19 called me.</p> <p>9/10/24 10:40AM V18, Scheduler, said as I walking in the hallway, I heard V19 telling someone on the phone this resident he doesn't sit down, he is getting on my nerves. V18 said I don't know who V19 was talking to. V19 said when I went in R5's room V19 was standing behind R5 holding him down. V18 said I told V19 it could be intimidating to be behind him.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 9/3/24 at 3:20PM V5 said V19 was assigned to R5 and from the start he was mad and upset because he did not have the option to refuse. V5 said one of the CNAs I spoke to said V19 called me and said he felt uncomfortable taking care of this patient because the resident was restrained. V5 said V18 called me on 7/26/24, after I had gone home, and said when she walked in R5's room V19 had R5 in a choke hold in the wheelchair, trying to hold him down, and talking on the phone. V5 said, V18 said V19 was on the phone talking to someone about how bad R5 is.</p> <p>On 9/10/24 at 11:51am V15, Assistant Director of Nursing, said there are no restraint use assessments because we are a restraint free facility.</p> <p>On 9/10/24 at 12:07PM V25, Administrator, said during orientation I say no restraints, unless notified otherwise, and then we would assess the resident on an as needed bases. V25 said I spoke with V19 yesterday (9/9/24) and all he could tell me is that when he got to the floor R5 had a gait belt on the chair. V25 said I asked if the ambulance had left him like that, V19 said he didn't know. The surveyor asked V25 if the ambulance transfers residents to them in wheelchairs, V25 said typically they don't come in with a wheelchair. V25 said the camera only shows the hallway. V25 said the camera looks down towards the dining room. V25 said there is only one camera, it can see the nurses' station, elevator, towards the dining room, and the entrance to the dining room. V25 said it is very blurry I can't make out a whole lot.</p> <p>On 8/29/24 an image of identified resident R5 obtained. Image is of African American, dark-skinned male, with disheveled, long, black hair, and long facial hair. R5 sitting in a room, in a wheelchair, no socks or shoes, in a hospital issued gown, with a face mask on, below his chin. A second image of a male, dark skinned, sitting in a wheelchair, leaning forward, back exposed. Image matches with the identified hallway of the facility hallway, outside of the elevator to the left, in front of the dining room door, below sprinkler device. R5 sitting across from nurses' station desk with the back of the computer monitor. The floor pattern and wallpaper match to the facility decor. A white with beige, red, and blue striped gait belt is visible with a long tail portion off the lower back of the wheelchair. A white linen, possibly bed sheet, is visible tied around the resident, left and right side of wheelchair have the same linen and 2 knots with a visible loop is present on the back of the wheelchair. No face for the resident is visible, but he is in a hospital gown and feet exposed, no shoes or socks. A blue scrub pant is visible in the lower corner of the image. A camera is observed in the vicinity directly in the line of sight where the resident in the picture is sitting.</p> <p>On 8/30/24 at 12:15PM V20, Human Resources, said V19 worked 7/26/24 3:00PM-11:00PM with a 30 minute lunch from 9:01PM- 9:30PM. V20 provided V19's time card.</p> <p>On 8/30/24 at 12:57PM V5 provided two samples of gait belts given to CNAs for use in the facility. One sample is beige with three stripes, blue, red, blue and metal clip. This belt is similar to the one seen in the picture used on R5.</p> <p>Review of R5's careplan and assessments. No risk of abuse assessment is in R5's chart. No restraint use assessment is in R5's chart.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Facility provided Restraint Policy and Procedure dated 1/15/21 states physical restraint is any manual method, or physical, or mechanical device, material, or equipment attached or adjacent to the individual's body that the individual cannot remove easily, which restricts freedom of movement or access to his or her body. Any resident that has restraint will have it removed during activities, meals, one to one and activities of daily living (ADLs) when and if staff can safely monitor the resident. Any resident requiring a physical restraint will be assessed prior to application to determine the least restrictive restraint used. A verbal consent at minimum will be obtained prior to the physical restraint application. A plan of care will be developed for all residents with chemical and physical restraints.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to follow their policy to report potential abuse violations to the abuse coordinator for one (R5) resident reported to be restrained, pictures were taken, and details of his care/condition were shared over the phone to unknown persons. This failure affected 1 of 3 residents reviewed. This failure resulted in perpetrator remaining with R5 to provide one on one care for the duration of his shift.</p> <p>The findings include:</p> <p>R5 is [AGE] years old with diagnosis including, but not limited to Convulsions, Alcohol Abuse with Alcohol Induced Anxiety Disorder, Depressive Episodes, Schizoaffective Disorder, Dementia, Acute Cystitis, and Bacterial Pneumonia. R5 was admitted to the facility on [DATE] around 2:00PM - 2:30PM (per DON). At 6:02PM R5 was ordered a psychiatric transfer, and transferred to the hospital on 7/27/24 at 12:25AM. R5 was admitted to the hospital.</p> <p>On 8/29/24 at 11:21AM V19, Certified Nursing Assistant (CNA), said on 7/26/24 I saw R5 had a gait belt around him. V19 said I was assigned to be R5's one to one, monitoring him. V19 said I talked to V11, LPN, and V5, DON, and the scheduler about the belt. V19 said I told V5 about the gait belt around R5 before she left like at 4:30PM. V19 said they said if you don't want to watch the patient, then go home. V19 said I left the floor and then I came back up to the floor around 6:00PM or 7:00PM and R5 had the sheet around him. V19 said I got fired because of this. V19 said I documented it, V19 provided pictures to IDPH from his personal phone.</p> <p>On 9/10/24 at 9:46AM V24, CNA, said on 7/26/24 around 5:00PM - 5:30PM I was at home when V19 called me, he said they stuck him with a one to one monitor. V24 said V19 said they were restraining the resident. V24 said I told V19 to tell V18 and to call the Administrator. V24 said V19 was going to document by taking pictures. V24 said I didn't report to anyone because I felt V19 had it under control and I didn't see it because I wasn't in the facility.</p> <p>On 9/10/24 at 10:40AM V18, Scheduler, said I heard V19 on the phone when I was walking in the hallway, after dinner between 5:15-5:30. V18 said I heard V19 telling someone this resident he doesn't sit down, he is getting on my nerves. V18 said I asked V19 if he was taking pictures and he said no he was not. V18 said I told V5, Director of Nursing, I heard V19 say I'm going to take pictures and send them. V18 said V24 mentioned V19 told her he was going to send pictures. V18 said I didn't see V19 take pictures. The surveyor asked V18 do you have to see abuse happen to report it? V18 said no. V18 said V19 stayed with R5 until the end of his shift. V18 said staff are not allowed to take pictures of the residents because it is a HIPPA (Health Insurance Portability and Accountability Act) violation. V18 said staff are not supposed to be on the phone while on duty with a resident. V18 said staff are not to be on the phone while assigned one to one monitoring with residents.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/30/24 at 12:29PM V5, Director of Nursing, said V19 was terminated for being on his cell phone, twice. V5 said on 7/26/24 I told him to get off the phone when I saw him. V5 said another staff observed V19 on the cell phone and heard V19 talking about R5 and how bad R5 was and R5 did not need to be here. V5 said when I spoke to V18 by phone, it may have been 9:00PM or 10:00PM. V5 said V19 did not finish his shift, we got someone else to monitor R5. V5 said taking resident pictures is a HIPPA violation. V5 said I told V18 to take V19 off the schedule until I speak with him on Monday.</p> <p>On 9/3/24 at 3:20PM V5, said V18, Scheduler, called me while I was at home and said when she walked in R5's room and saw V19 on the phone. V5 said V18 reported V19 was on the phone talking to someone about how bad R5 is and something about pictures. V5 said V18 said V19 had R5 in a choke hold in the wheelchair, trying to hold him down, and talking on the phone. V5 said after the surveyor spoke with me (on 8/30/24) I spoke with my staff and V24 said V19 called me and said he was going to take pictures of the resident. V5 said V24 said she didn't report it because it didn't involve me and she didn't want to get involved. V5 said V18 and V24 should have both reported V19 on 7/26/24. V5 said V19 was assigned to R5 and from the start he was mad and upset because he did not have the option to refuse. V5 said one of the CNAs I spoke to said V19 called her and said he felt uncomfortable taking care of this patient because the resident was restrained.</p> <p>On 8/30/24 at 12:15PM V20, Human Resources, said V19 was terminated for being overheard talking on the phone about a resident while on one to one monitoring with a resident. V20 said V19 was terminated on 7/29/24. At 12:57PM V20 presented V19's time card and said he had no actual punches, I had to manually enter his time. V20 said on V19's time card the entry for 7/29/24 should be his time for 7/26/24. V29 said V19 worked 7/26/24 3:00PM -11:00PM with a 30 minute lunch from 9:01pm- 9:30PM. V20 said we don't use miss punch forms, I enter the hours based on the schedule that V18 gives me. V20 presented a schedule and said it shows V19 worked 3:00PM - 11:00PM on 7/26/24.</p> <p>On 9/10/24 at 12:07PM V25, Administrator, said V19 probably should not have completed the shift on 7/26/24. V25 said V19 talking about R5 on the phone violates policy. V25 said if I had been there, V19 would not have been allowed to return to the floor after walking out. V25 said I did not know anything occurred with R5 until V5 spoke with me after she spoke with the surveyor.</p> <p>V19 employee file notes his hire date is 7/10/24. Review of V19's employee file conducted. V19's HIPPA Quiz dated 7/10/24 has no responses for the questions. On 7/10/24 V19 signed I acknowledge that I have received and read the facilities abuse prevention program policy and procedure. I have received and read the social media policy. I understand the requirements of the social housing policy represents the standards and policies of the facility.</p> <p>V19's time card indicates he worked 7/26/24 3:00PM - 11:00PM and was not sent home as V5 said during her interview.</p> <p>IDPH received three pictures of R5 on 8/29/24 at 11:49AM. According to V19's time card, the last time V19 worked was on 7/26/24. R5 retained the pictures in his phone for 34 days.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility abuse prevention program updated 01/2019 states 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 to the administrator. If you suspect abuse separate the alleged perpetrator and assure all residents safety. Do not leave the building until above is completed. Fax report to IDPH immediately. All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, crime against a resident will be documented and result in an abuse investigation. Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and suspended from duty, pending the outcome of the investigation, prosecution, disciplinary action against the employee.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796</p> <p>Based on interviews and records reviewed the facility failed to de-escalate a verbal altercation that escalated to physical altercation, R6 hit R7 with a cane. This affected 2 of 2 residents (R6, R7) reviewed for supervision.</p> <p>Findings include:</p> <p>Facility final report to the department with date of incident of 8/19/24 denotes in-part, R6 and R7. Brief description of incident: above residents were out on patio for supervised smoke break. R6 asked R7 a question, when R6 didn't receive anticipated response, he swung his cane and hit R7. R7 became upset and picked up chair and hit R6. Nurse on duty was immediately called to area, residents were separated. Nurse performed assessment of both residents, with no new areas of concern noted. Physician (psychiatrist) for both residents was called with orders to send R6 to nearest emergency room and to monitor R7. 1:1 supervision provided to both residents pending discharge of R6. Facility room change will be initiated upon R6 return. Conclusion: abuse is the willful intent to inflict harm to a person. The facility has conducted a thorough investigation and cannot substantiate abuse. R6, resident #,1 is a [AGE] year-old B/M (black male) who is A/O (alert and orient) x 2. He has a BIMS of 11 and is moderately impaired. He has a h/o hallucinations and delusional thinking. He believes that he hears things and when staff tells him that what he is hearing and saying is not true, he tends to get agitated, angry, and upset. R7, resident # 2, is a [AGE] year-old H/M (Hispanic male) that is A/O x 3. He has a BIMS of 14 and is cognitively intact. Both residents were outside on the patio area for smoke break. R6 was hallucinating and asked R7 if he knew a particular woman. R7 said No. R6 continued to accuse R7 of knowing the woman. They began arguing when R6 hit R7 with his cane. R7 then picked up a chair and hit R6, to defend himself. Staff immediately separated them. The nurse assessed both residents. There were no obvious signs of injury. The physician, who is the Psychiatrist for both residents, ordered R6 to be sent to the ER (emergency room) for eval/Tx (treatment). He was transported to (hospital initials), by ambulance in stable condition, evaluated, and returned to the facility. Families/POA, DON, Administrator were notified. All staff who cared for R6 reports that he does hallucinate and has delusions and can be difficult to redirect. All staff who cared for R7 states he is calm and does not bother anyone. R6 has DX (diagnosis) of bipolar disorder and paranoid schizophrenia. At times, he is unaware or unable to control his thoughts or actions when he is hallucinating and is unaware of how his actions can be interpreted by other residents. Abuse is the willful intent to inflict harm to a person. The facility has conducted a thorough investigation and cannot substantiate abuse. Upon his return to the facility, R6 was immediately transferred off the unit to a new room on the 2nd floor. The family was notified of the room change. He remains at his baseline for mood and behavior. R6 care plan was updated accordingly. All assessments were updated. R7 remains at his baseline for mood and behavior. R7 care plan was updated accordingly. All assessments were updated.</p> <p>R6 face sheet shows R6 has diagnosis of bipolar, and paranoid schizophrenia, R6 MDS (minimum data set) dated 8/2/24 shows R6 is 224 pound and 69 inches tall, section C for cognition shows R6 BIMs score is 15 (cognitively intact), section E for behaviors shows delusions and hallucinations box is checked and there is number one denoting verbal behavior symptoms directed towards others, behavior of this type occurs 1 to 3 times day.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24 at 11:08am, R6 observed alert to person, place, time. R6 said R7 owed him some money, R6 said his family gave (unknown female) his money and (unknown female) gave it to R7. R6 said (unknown female) gave R7 one million dollars of his money. R6 said he was on the patio, he asked R7 did he know (unknown female), and R7 said no. R6 said R7 picked up a chair and he blocked the chair with his cane and the chair only hit his wrist. R6 denied that he had any injuries. R6 said he went to the hospital afterwards, but he returned to the facility the same day. R6 said he is suing the other facility that he was living in. R6 said he wrote the (popular TV show) back in the 60's and the (broadcast station name) stole his idea. R6 said R7 owes him one million dollars. R6 said he feels safe at the facility.</p> <p>On 9/10/24 at 11:31am, R7 observed alert to person, place, and time. R7 said R6 asked him something about a female, he told R6 that he did not know that person, R7 said R6 went on and on. R7 said R6 got mad and hit him with his cane. R7 said he picked up the chair so that R6 does not keep hitting him, R7 said he didn't throw the chair at R6 intentionally, he was trying to block R6 from hitting him. R7 said R6 hit his own arm on the chair when he was trying to hit him with the cane. R7 said R6 is always bothering everyone, asking them stuff. R7 said he feels safe at the facility.</p> <p>On 9/10/24 at 11:26am, V14 (CNA) said she was on the smoking patio monitoring when R6 asked R7 did he know (unknown female), R7 told R6 that he did not know who that was. V14 said R7 asked R6 to leave him alone. V14 said R6 hit R7 with his cane, V14 said R7 picked up the chair blocking R6. During a follow up interview on 9/11/24, V14 said both residents were throwing chairs. V14 said she could not stand between the resident and the chair, she is small and can't handle those male residents. V14 said R6 has delusions that someone has his check, that someone is on the 4th floor with his wife, and he keep asking do we know (unknown female), he said he wrote the (popular TV show).</p> <p>On 9/11/24 at 10:14am, V12 (social worker) said there was an incident with R6 hitting R7 with his cane, R7 picking up the chair to defend himself from R6, V12 said R7 was not the instigator. V12 said R6 thinks his wife is on the 4th floor having sex, he keeps saying someone got his check, he says he wrote the (popular TV show). V12 said R6 had stopped taking his medications and his delusions increased during that time.</p> <p>R7 MDS shows R7 is 133 pounds and 65 inches tall. Section C shows BIMS score of 14 (Cognitively intact).</p> <p>V14 and V12 said the name (unknown female) is not known to the facility.</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>40066</p> <p>Based on interviews and records reviewed the facility failed to ensure a STAT order for a chest x-ray for new chest bruising was carried out within 4 hours. This affected one of one (R1) residents reviewed for radiology orders.</p> <p>The findings include:</p> <p>On 8/28/24 at 2:10PM, V2 Registered Nurse said, a STAT order means as soon as possible.</p> <p>On 8/28/24 at 1:59PM, V3 LPN said, on 7/29/24 when I came on shift, I was told we were waiting for an x-ray on R1. V3 said they said would get there. V3 said, then during my 5:00PM medication pass I was notified that R1 was not breathing. I assessed him, felt for a pulse, he was cold, not breathing, I called a code blue, and called 911.</p> <p>On 8/30/24 at 11:10AM, V5 DON said, on 7/29/24 R1 had yellowish and purplish bruising, right under the breast area. V5 said, we asked the nurse practitioner to assess him. V5 said, she ordered labs and x-rays. V5 said, we were waiting on diagnostic company to come in, then R1 had a change in condition, and he was sent out. V5 said, STAT means right away, the expectation is they are in the facility within 4 hours. V5 said, the nurses are to call within 4 hours and get estimated time of arrival and update. V5 said, R1 left to the hospital between 5:00PM- 6:00PM. V5 said, we obtained the x-ray orders in the morning between 10:30AM-11:00AM. V5 said, the Diagnostic company took longer than the 4 hours. At the end of the interview the surveyor requested the diagnostic company contract with the facility.</p> <p>On 9/3/24 at 11:13PM, V23 Nurse Practitioner said, I ordered STAT labs on R1 to see if he was bleeding or if something was broken. V23 said, there was a lot of bruising that was concerning. V23 said, I expect a STAT order to be done in 2 hours and call and notify me of results. V23 said, they did not notify me the x-ray was not done. V23 said, without the x-ray we can't know if R1 had a fracture. V23 said, bruising can be a sign of fracture, and pain is not necessarily a sign. V23 said, a fracture can be present without pain. V23 said, I ordered the x-ray to be sure there was no fracture, and it is normal protocol.</p> <p>On 9/3/24 at 12:25PM, V5 said, I'm still waiting on corporate to send the Diagnostic contract and the Stat Orders policy.</p> <p>The facility's Final report dated 8/2/24 to IDPH states R1 observed with ecchymosis extending across the chest wall. At approximately 9:45AM the nurse practitioner was notified of the bruising. Order for STAT labs and chest x-ray was given. At approximately 6:30PM the resident had a change of conditions and was transported to the hospital.</p> <p>Progress notes dated 7/29/24 4:31PM notes writer followed up with STAT order. Company states they will be out today.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided the Physician Order policy date 12/2014. This policy does not address STAT orders. The facility did not present a Diagnostic contract to the surveyor.</p>		