STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Rehab & Care Center	601 North Columbia West Frankfort, IL 62896

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)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on observation, interview, and record review the facility failed to allow residents to choose to reside in the same room with their spouse and visit other residents for 2 out of 3 residents (R300 and R301) reviewed for resident rights in a sample of 14. Findings include: 1. On 5/8/2024 at 9:55 AM, R300 was interviewed and stated My wife lives here, and they made her move so they could put this man in here. My wife moved here from another facility so we could be together and now we can't be together. I can't go to her room and visit her because I cannot go past the double doors. (V34 Certified Nursing Assistant/ CNA) told me I cannot go down that hall through the double doors so I can't even get my haircut. R300's document titled Admission Record documented an admitted 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. R300's 4/15/2024 MDS (Minimum Data Set) documents the BIMS (Brief Interview for Mental Status) score of 13, which indicates R300 is cognitively Intact. On 5/8/2024 at 10:46 AM, R301 who was alert and oriented stated I came here because my husband was admitted here, we were in the same room, but they moved me. There was too much drama going on and now they won't let him come down here and visit me. My husband was told by (V34) that he could not come down here and visit and I don't know why. We only see each other at meals. My husband (R300) and I do not know exactly why they moved me, but they admitted a new man and put him in the room with my husband (R300). R301 stated I would like to be in the room with my husband but (V6 Social Services Director) told me that I had to move. R301 stated Nobody has even been back down or asked me if I wanted to be with my husband. I moved here to be with my husband. On 5/8/24 at 12:10 PM, R301 was in the dining room talking and having lunch with her husband (R300). R301 asked if they could be back in the room together. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R301's document titled Admission and Discharge Record documents an admitted [DATE] and was admitted from another long term care facility. This same document also included diagnoses of: Type 2 DM, Anxiety, Hypertension, Anemia, Angina Pectoris, GERD, Heart Failure, Depression, History of TIA, and Cerebral Infarct with no residual. R301's MDS (Minimum Data Set) dated 4/22/2024 documented a BIMS (Brief Interview for Mental Status) score of 15, indicating intact cognition. On 5/10/2024 at 10:58 AM, V6 SSD (Social Service Director) stated she was unaware of a reason why R300 could not go down to visit R301. V6 stated (R300) had said he couldn't go through the double doors, but I was unaware of reason why he was told that. V6 stated R300 reported (V34 CNA) told him he could not go through the double doors, but nobody knows why and there is no rule about that. V6 stated R301 came and told her that R300 was getting on her nerves and wanted to move rooms. V6 stated she moved R301 to another room. V6 was asked if she has followed up to see if R301 was happy not being with her husband (R300) and V6 stated No, I have not followed up. On 5/10/2024 at 10:22 AM, R301 stated I told them I wanted to move but they wouldn't do it. I think they needed that room for that other man. On 5/8/24 at 2:00 PM, R301's medical record was reviewed and there were no notes pertaining to R301 and R300's rooming preferences under the social services tab. On 5/10/2024 at 12:05 PM, V6 brought in a document titled Social Service Progress Notes with a written note dated 5/10/2024 which documented in part .Spoke (with R301) regarding room (change). Requested to be moved back in (with) husband (R300). Explained we could do it but will require us to move a few people, (and) may not happen until Monday 5/13/2024. (R301) stated she was ok with waiting. Will follow up Monday (morning with changes.) signed by V6. On 5/16/24 at approximately 12:00 PM, the facility presented another document titled Social Progress Notes allegedly from R301's medical record. The first entry on the documented was dated 5/4/25'24 (sic) and the second entry was dated 5/3/24. The 5/4/25'24 (sic) entry documented in part . Resident stated that she wanted to get away from husband (R300). (Change) rooms. Asked resident why. Stated she wanted to get away from him. I don't want to talk (with) him. She asked if she could move down at the other end of hall (with another resident). Spoke (with other resident) regarding (R301) as room-mates. (other resident) was happy (and) like (R301). Spoke with admin regarding request for room (change) . signed by V6. The 5/3/24 entry documented in part . (R301) requested to (change) rooms because room-mate kept her up last night yelling screaming. Spoke (with) nursing staff regarding (R301) unable to sleep. Stated room-mate was up a lot last night, had some (medication changes). Spoke (with R301) stated will check to see if we could move, but room availability was slim. Asked if (R301) would like to move in (with) husband (R300) or another female. (R301) stated she did not want to move in (with R300) . signed by V6. On 5/14/2024 at 9:10 AM, R301 was sitting in the dining area with her husband and stated, We are in the room together finally. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/2024 at 2:50 PM, V44 RDO (Regional Director of Operations) stated there was no policy for resident rights pertaining to romantic partners choosing to reside in the same room, but she would expect for a married couple to be able to share a room if that is what they request, and residents should be able to visit other residents if they wish to do so.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 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 in the sample of 14. 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 Immediate Jeopardy began on 5/7/24 at approximately 2:00 AM when V34 (Certified Nursing Assistant/CNA) verbally and physically abused R26 by ripping R26's clothing while transferring R26 to the wheelchair and wheeling R26 to the dining room to wait for breakfast. V44 (Regional Director of Operations) was notified of the Immediate Jeopardy on 5/15/24 at 12:35 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 5/16/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: 1. R26's document titled Admission Record documented an admitted [DATE] 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. 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 for shower and bathing, and lower body dressing; and partial to moderate assistance with transferring. R26's care plan did not document R26 having the potential for abuse. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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. 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 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 was for a resident to fully understand what is about to happen. 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. 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 (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 . 2. R44's face sheet documented an initial admitted [DATE] 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. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/10/2024 at 12:20 PM, R44 was interviewed but was a poor historian with some confusion noted. 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. 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. 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. 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 (V34) get in trouble . 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). 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. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 . 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. 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. 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. 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 resident property and exploitation . The Immediate Jeopardy that began on 5/7/24 was removed on 5/16/24 when the facility took the following actions to remove the immediacy. Immediate actions: 1. For the Resident found to be affected by the alleged deficient practice, the following corrective action has been taken to achieve compliance: A. IDT (Interdisciplinary Team) team has assessed (R26) and care plan updated to reflect potential for abuse and interventions to protect (R26) from abuse. Completed on 5/15/2024. B. (V34 CNA) had been suspended on 5/10/2024 pending outcome of an investigation and was terminated on 5/14/24. 2. The following systematic measures have been implemented to ensure that the revised 11/28/16 Abuse Prevention Program policy is being followed: A. Facility Abuse Prevention Policy was reviewed on 5/13/24 and was found to be in compliance with state and federal regulations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	B. On May 14, 2024 (V44) Regional Director in-serviced the Administrator (V1) on the Abuse Prevention Policy, which included identifying types of abuse, investigating and reporting all alleged abuse allegations and immediately suspending employee, accused. C. Facility Administrator (V1) initiated in-servicing, for all staff, on the Abuse Prevention Policy on 5/16/2024 prior to their shift, all staff on shift and will inservice all other staff prior to their next shift. D. The Administrator (V1) will interview 3 staff members, 3 times weekly x 4 weeks to ensure that staff, understand the Abuse Prevention Policy, timely reporting of abuse, who to report abuse to, types of abuse and immediately separating residents or suspending a suspected staff member. Initiated on 5/14/2024. E. Resident council meeting was conducted on 5/14/24 to review the Abuse Prevention Policy and how to report abuse or perceived mistreatment. Resident council president and IDT team members present. F. Social Service Director (V6) will interview 3 residents, 3 times weekly x 4 weeks to ensure understanding of abuse and reporting of any abuse or perceived mistreatment, by another residents or a staff member. Initiated on 5/14/2024. G. IDT team reviewed all residents for the potential of abuse and care plans updated to reflect interventions to protect residents from abuse. Completed on 5/16/2024. H. IDT in-serviced to review any resident for changes in behaviors, increase in behaviors or new behaviors in order to investigate and identify any potential triggers prior to an incident, ensure that person centered interventions are developed to alleviate/decrease behaviors and to communicate identified triggers and interventions to staff. Initiated on 5/14/2024. 3. As part of the facilities ongoing quality assurance program: A. Residents who trigger during this IDT review will be discussed during morning meeting and a root cause analysis will be completed to determine potential triggers. Individualized intervention will be developed to decrease episodes of behaviors, in order to prevention situations that may cause abuse to a resident. (on-going).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview and record review, the facility failed to identify and report allegations of staff to resident verbal abuse immediately to the Administrator and failed to report and allegation of abuse to the Illinois Department of Public Health (IDPH) for 3 of 5 residents (R44, R46, and R300) reviewed for abuse in the sample of 14. Findings include: 1. R46's face sheet documented an initial admitted [DATE] 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. 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. On 5/8/24 at 9:56 AM, R46 said a CNA (Certified Nursing Assistant) told him to turn his f**king music down. R46 said he (V32/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 R46, and the incident didn't happen. R46 said V1 told him that V1 did not believe R46. R46 said he did not feel safe when V34 was working. V46 said he did not feel safe when V34 was working. V46 said he had not told V1 he did not feel safe while V34 was working because V1 had never asked. On 5/8/24 at 12:26 PM, V40 (Housekeeper) stated R 46 told her V34 had cussed him out in the dining room on 5/3/2024 due to his music being played too loud. V40 said she had reported R46's abuse allegation to V42 (Licensed Practical Nurse/ LPN) and had given V42 a written statement. On 5/8/24 at 1:16 PM, V42 (LPN) said on 5/4/24 that V40 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. On 5/8/24 at 2:20 PM, V1 (Administrator) said she was aware of R46's abuse allegation but had not reported it to Illinois Department of Public Health (IDPH). V1 said R46's abuse allegation was not substantiated so V1 did not feel the allegation needed to be reported. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 2. R44's document titled Admission Record documented an admitted [DATE] with diagnoses including aftercare following Joint Replacement Surgery, Paranoid Schizophrenia, Atherosclerotic Heart Disease, Conversion Disorder with Seizures or Convulsions, Gout, Hypertension, Schizoaffective Disorder, Bipolar Type, Hypothyroidism, Anxiety, Polyosteoarthritis, Hyperlipidemia. R44's MDS (Minimum Data Set) dated 3/8/2024 documented a BIMS (Brief Interview for Mental Status) score of 00, indicating severe cognitive impairment. On 5/10/2024 at 12:15 PM, V37 CNA (Certified Nurse Assistant) stated he has received training on abuse during employment at the facility. V37 stated I have never witnessed physical abuse, but I have witnessed verbal abuse and threats to residents. V37 stated he had witnessed an incident of verbal abuse/threat to R44 by V34 (CNA). V37 stated R44 had just returned from the hospital, and something was wrong with his stomach. V37 stated R44 kept putting on his call light thinking he felt like he needed to use the restroom but when staff would get to R44's room, R44 felt like the need to use the restroom had passed. V37 stated that he went into the room with V34 and witnessed V34 threaten R44 by telling him he (V34) was going to take his call light away from him if he didn't stop turning the call light on. V37 stated he didn't report the incident involving verbal abuse to R44 because he wanted to give V34 a chance but it didn't do any good, I guess. On 5/10/2024 at 12:20 PM, R44 was interviewed but was a poor historian with some confusion noted. 3. Document titled Admission Record documented R300 admitted 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. R300's MDS dated [DATE] documents a BIMS a score of 13, which indicates R300 is cognitively intact. On 5/8/2024 at 9:59AM R300 who 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 R300 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. (continued on next page)

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	145664	A. Building B. Wing	05/21/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/10/2024 at 11:20 AM, V38 PRSC (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. 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. 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. 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 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. Document titled Abuse Prevention Program with Revised date of 11/28/2016 documented in part, section IV . Internal Reporting Requirements and Identification of Allegations . employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator . Supervisors shall immediately inform the administrator or his/her designated presentative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents of residents and misappropriation of resident property. VII. External Reporting of Potential Abuse . 1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse . are reported immediately to the administrator of the facility . If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least on law enforcement agency of jurisdiction and IDPH immediately after forming the suspicion . otherwise, the report must be made not later than 24 hours after forming the suspicion .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview and record review, the facility 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. Due to this failure R26 was verbally and physically abused by V34 (Certified Nursing Assistant/CNA) on 5/7/24 at approximately 2:00 AM. This also had the potential to affect all 47 residents residing in the facility. Findings include: 1. Document titled Admission Record documented R300 admitted 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. R300's Minimum Data Set (MDS) dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 13, which indicates R300 is cognitively Intact. 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. On 5/10/2024 at 11:20 AM, V38 PRSC (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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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 V34 on 5/10/2024 and V34 was suspended at that time. 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. 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. 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. 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. 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 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. 2. R26's document titled Admission Record documented an admitted [DATE] 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. 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. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	On 5/8/2024 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 night shift CNA, 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. 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 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. R26 stated facility staff were aware of V34 being abusive but nobody does anything about it. On 5/10/24 at 2:07 PM, R26 said the last time he had issues with his care by V34 (CNA) had been Monday night 5/6/24 / Tuesday morning 5/7/24. On 5/10/24 at 3:14 PM, V34 (CNA) said R26 was assisted with care around 2:00 AM during bed check. V34 said R26 was usually one of the last residents V34 would assist because R26 was 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. R26 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). 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 and 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 was for a resident to fully understand what is about to happen. 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 states that CNA talks rudely to him . Regional Director interviewed (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 is 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 . On 5/10/2024 at 12:30 PM, R37 was alert and oriented. R37 is a roommate of R26 and 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 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. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	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 due to the R300 abuse allegation. 3. R44's document titled Admission Record documented an admitted [DATE] with diagnoses including aftercare following Joint Replacement Surgery, Paranoid Schizophrenia, Atherosclerotic Heart Disease, Conversion Disorder with Seizures or Convulsions, Gout, Hypertension, Schizoaffective Disorder, Bipolar Type, Hypothyroidism, Anxiety, Polyosteoarthritis, Hyperlipidemia. R44's MDS (Minimum Data Set) dated 3/8/2024 documented a BIMS (Brief Interview for Mental Status) score of 00, indicating severe cognitive impairment. On 5/10/2024 at 12:15 PM, V37 (CNA) stated he has received training on abuse during employment at the facility. V37 stated, I have never witnessed physical abuse, but I have witnessed verbal abuse and threats to residents. V37 stated he had witnessed an incident of verbal abuse/threat to R44 by V34 (CNA). V37 stated R44 had just returned from the hospital, and something was wrong with his stomach. V37 stated R44 kept putting on his call light thinking he felt like he needed to use the restroom but when staff would get to R44's room, R44 felt like the need to use the restroom had passed. V37 stated that he went into the room with V34 and witnessed V34 threaten R44 by telling him he (V34) was going to take his call light away from him if he didn't stop turning the call light on. V37 stated he didn't report the incident involving verbal abuse to R44 because he wanted to give V34 a chance but it didn't do any good, I guess. On 5/10/2024 at 12:20 PM, R44 was interviewed but was a poor historian with some confusion noted. 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 he had joked with R44 after answering R44's call light V34 had gotten about halfway down the hall when R44 turned his call light on again. V34 said he had joked with R44 saying what do you need 5 seconds later. 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 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. 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. R44's document titled Incident Investigation Form documents V44 (Regional Director of Operations) interviewed V37 (CNA) dated 5/14/2024. Document reads .(V34) - (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 he was busy and didn't want to see (V34) get in trouble . (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	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). 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. 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. 4. R46's face sheet documented an initial admitted [DATE] 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. 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. 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. On 5/8/24 at 12:26 PM, V40 (Housekeeper) said she reported that R46 had made an abuse 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. 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. 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. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	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 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. 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. 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. On 5/13/2024 at 3:23 PM, via phone interview 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. The facility's undated census list provided on 5/7/24 documented 47 residents residing in the facility. 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 .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Rehab & Care Center	601 North Columbia West Frankfort, IL 62896

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview and record review the facility administration knowingly failed to report abuse allegations, thoroughly and timely investigate abuse allegations, suspend staff pending facility abuse investigations, and inaccurately document resident assessments for 3 of 5 residents (R26, R46, and R300) reviewed for administration in a sample of 14. This failure has the potential to affect all 47 residents residing in the facility. Findings include: 1. On 5/10/2024 at 11:20 AM, V38 PRSC (Psychiatric Rehabilitation Service Counselor) stated R300 came to her on Friday evening (5/3/2024) and reported an 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. R300's Minimum Data Set, dated dated dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 13, which indicates R300 is cognitively Intact. On 5/7/24 at 9:10 AM, V1 (Administrator) said she was aware R300 had reported the allegation of abuse to V6 (Social Services Director) on the evening of 5/6/24. 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 V34 on 5/10/2024 and V34 was suspended at that time. 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 of R300's abuse allegations. 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. 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 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. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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 V1 (Administrator) to have suspended V34 (CNA) on 5/6/2024 when the abuse allegation was made my R300. V44 said she expects all staff to be interviewed in an abuse allegation investigation. On 5/10/24 at 12:11 PM, V51 (Licensed Practical Nurse/ Care Plan Coordinator/ Minimum Data Set Coordinator) said she had revised R300's care plan on 5/7/24 due to R300 making false allegations. V51 said the only allegation V51 was aware of was R300 alleging being tackled by a staff member on the nightshift. V51 said she had been made aware of R300 making false allegations about staff members during the morning meeting on 5/7/24. V51 said she was unable to recall who had reported to her in the 5/7/24 morning meeting R300 needed a care plan about making false allegations. V51 said she had updated R300's care plan to reflect the behavior tracking sheets (completed on 5/7/24 by V6 Social Services Director) in the behavior tracking binder. R300's care plan documented a date initiated 5/7/24 documenting in part . The resident voices false allegations . with 5/7/24 interventions including Reward the resident for appropriate behaviors (as needed) and If reasonable, discuss the resident's behavior. Explain/ reinforce why behavior is inappropriate and/ or unacceptable to the resident. On 5/10/24 at 12:31 PM, V6 (Social Services Director) said on 5/7/24 around 2:00 PM V6 had been asked by V1 (Administrator) to make behavior tracking sheets for R300 pertaining to R300 making false allegations. V6 said she was not aware of R300 making any false allegations or any staff members reporting to V6 that R300 was making false allegations. V6 was asked if a resident makes an allegation of abuse, and it is not substantiated does the resident automatically get a behavior tracking sheet for making false allegations? V6 responded no. V6 said a resident would get a behavior tracking sheet if they made allegations such as not getting a meal tray when staff knew the resident had received a meal tray. V6 reviewed R300 5/7/24 care plan The resident voices false allegations and said she was unsure why V47 (LPN/ Care Plan Coordinator/ Minimum Data Set Coordinator) had updated R300 care plan on 5/7/24. V6 said she did not know what the reward would be after reading the 5/7/24 intervention of Reward the resident for appropriate behavior (as needed). V6 said she did not think the 5/7/24 care plan intervention If reasonable, discuss the resident's behavior. Explain/ reinforce why behavior is inappropriate and/ or unacceptable to the resident was an appropriate intervention and that could cause staff not to believe R300 when R300 made abuse allegations. R300's medical record Nurses Notes from 4/5/24 through 5/14/24 were reviewed and did not document any instances of R300 making false allegations or being physically aggressive with staff. R300's May 2024 Behavior Tracking Record documented in part . Diagnosis: Anxiety . Target Behavior: (R300) makes False accusations involving staff and other residents . documentation by staff started on 5/7/24 on the 10:00 PM to 6:00 AM box. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/10/24 at 12:53 PM, V48 (Registered Nurse/ RN) said she was familiar with R300. V48 said she would sit and talk to R300 at the nurse's station regularly. V48 said she was not aware of R300 making any false allegations about staff. V48 said if R300 made an abuse allegation she would report it to V1 (Administrator) immediately. V48 was then read R300 5/7/24 care plan . The resident voices false allegations . with 5/7/24 interventions including Reward the resident for appropriate behaviors (as needed) and If reasonable, discuss the resident's behavior. Explain/ reinforce why behavior is inappropriate and/ or unacceptable to the resident. V48 said she would try to follow a resident's care plan as best as she could. V48 said with R300's 5/7/24 intervention of If reasonable, discuss the resident's behavior. Explain/ reinforce why behavior is inappropriate and/ or unacceptable to the resident she would explain why the behavior is inappropriate to R300 if R300 made an allegation of abuse. V48 said she didn't know what would be an appropriate reward would be for R300 not reporting abuse. 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. 2. On 5/8/2024 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 night shift CNA, 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. 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. 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 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. R26 stated facility staff were aware of V34 being abusive but nobody does anything about it. On 5/10/24 at 2:07 PM, R26 said the last time he had issues with his care by V34 (CNA) had been Monday night 5/6/24 / Tuesday morning 5/7/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 (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 is 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 . 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 due to the R300 abuse allegation. 3. 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 Certified Nursing Assistant/ 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. 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. 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. 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 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. The facility's undated census list provided on 5/7/24 documented 47 residents residing in the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 resident property and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secured environment. The facility is committed to protecting our residents from abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members, or legal guardians, friends, or any other individuals . section IV . Internal Reporting Requirements and Identification of Allegations . employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator . Supervisors shall immediately inform the administrator or his/her designated presentative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents of residents and misappropriation of resident property. 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 . VII. External Reporting of Potential Abuse . 1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse . are reported immediately to the administrator of the facility . If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least on law enforcement agency of jurisdiction and IDPH immediately after forming the suspicion . otherwise, the report must be made not later than 24 hours after forming the suspicion . The facility's undated Administrative Services policy received on 5/10/24 at 10:29 AM documented in part . (Facility company name) shall designate a Nursing Home Administrator who is licensed by (or is eligible for licensure in) the State in which the facility is located . the Administrator shall be familiar with, and responsible for, meeting all applicable regulations and familiarizing employees with regulations applicable to their responsibilities .