

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145866	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/19/2024
NAME OF PROVIDER OR SUPPLIER  Hickory Vlg Nrsng & Rhb		STREET ADDRESS, CITY, STATE, ZIP CODE  9246 South Roberts Road Hickory Hills, IL 60457	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40102</p> <p>Based on interview and record review, the facility failed to follow their abuse policy by allowing a staff member to tease and laugh at a resident. This failure affected one of three residents (R2) reviewed for abuse.</p> <p>Findings Include:</p> <p>R2 is a [AGE] year old with the following diagnosis: bipolar disorder, schizophrenia, and drug induced parkinsonism.</p> <p>R3 is a [AGE] year old with the following diagnosis: bipolar disorder, anxiety, and spina bifida.</p> <p>The Final Incident Report dated 7/3/24 documents R2 reported to V1(Adminsitrator) on 6/27/24 that V5, V8, and V9 were verbally inappropriate to R2 on the overnight shift on 6/23 through 6/24/24. R2 reported staff were calling R2 names and talked about R2 's mom. R2 also stated staff laughed at R2. Upon interview, the three staff members denied the allegation. They stated R2 was very shaky and was being monitored in the dining room due to being a potential fall risk. R3 witnessed V5 and V8 in the dining room with R2. R3 stated a similar version that V5 and V8 were picking on R2 and laughing at R2.</p> <p>On 7/16/24 at 11:52AM, R2 stated there was an incident about 3-4 weeks ago where two CNAs (V5 and V8) were making rude comments about R2 and disrespectful comments about R2 's mother. R2 could not remember exactly what V5 or V8 were saying but felt they were making fun of R2 and laughing at R2. R2 stated this happened in the dining room. R2 reported asking V5 and V8 be put back to bed to go to sleep and they refused so R2 had to stay up all night in the dining room. R2 stated R2 was upset that night but now does not even think about what happened unless someone else talks about the incident. R2 then went to the hospital on 6/24/24 due to shaking and tremor movements. R2 stated telling V2 (Nurse) about the incident when R2 arrived back from the hospital. R2 reported being called into the office and told V1 what happened.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/16/24 at 12:04PM, when asked if there was an incident that occurred between R2 and staff members, R3 stated 2 female CNAs (V5 and V8) bullied and were being disrespectful and rude to R2 on a night shift in June of 2024. R3 could not remember the specific date. R3 reported R2 was sitting in a high back wheelchair in the small dining room diagonally across from the nurse ' s station. R3 confirmed R2 was being monitored by V5 and V8, but when R2 was calling out for help V5 and V8 would yell at R2 to stop moving and sit back down. R3 stated R2 asked to go lay back down in bed and one of the CNAs told R2 no because R2 was acting crazy. R3 reported one of the CNAs also told R2 that they do not care that R2 wants to go lay down in bed and R2 need to chill the f*ck out. R3 was unable to remember the exact wording but confirmed one of the CNAs made a comment about R2 ' s mom in a derogatory manner. R3 stated R3 was working on a laptop in the dining room so R3 could hear what V5 and V8 were saying. R3 stated both CNAs were making comments and R3 knew this because R3 is familiar with both of their voices. R3 reported V9 (Nurse) was sitting at the nurse ' s station and was able to hear what V5 and V8 were saying to R2 but at no point did V9 intervene. R3 confirmed hearing V9 say, This is going to show her how she needs to act. R3 stated witnessing this incident around 1-2AM but R3 left the dining room around 3AM to go to sleep and R2 was still sitting in the dining room with V5 and V8. R3 reported R2 seemed very nervous and kept shaking R2 ' s whole body but V5, V8, and V9 only told R2 to calm down and did not offer any other assistance. R3 stated about three or four days later R3 was pulled into the office for questioning by V1 and R3 told V1 what R3 witnessed that night. R3 confirmed V5 and V8 no longer work at the facility after hearing other staff talk about it.</p> <p>On 7/16/24 at 1:45PM, V2 (Nurse) stated when R2 got back from the hospital, R2 reported two staff members were mean to R2. V2 reported R2 was not able to remember their names but could describe the two CNAs (V5 and V8) perfectly. V2 stated R2 reported R2 needed help going to bed and V5, V8, or V9 (Nurse) would not help R2 back to bed that night. V2 reported V5, V8, and V9 were terminated due to this incident. V2 stated this incident would be considered verbal abuse for the staff saying mean things to R2 and for mental abuse for not putting R2 back to sleep when R2 requested.</p> <p>On 7/17/24 at 8:11AM, V5 (Former CNA) stated R2 was all over the place that night and the nurse (V9) said R2 was not allowed to go back to bed due to being a fall risk. V5 reported a couple days later V5 was called into the office and made aware of the allegation against V5. V5 denied bullying R2 but admitted to R2 asking to go to bed and V5 did not put R2 back to bed. V5 stated R3 was in the dining room during that shift.</p> <p>On 7/17/24 at 11:42AM, V8 (Former CNA) stated the nurse (V9) told V5 and V8 to keep R2 up in the dining room to be monitored during the night. V8 reported R2 kept shaking R2's entire body and the nurse told V8 it was just muscle spasms. V8 stated R2 then went out to the hospital for the spasms and upon return reported the allegation of abuse to management. V8 reported being told that R2 told V1 that V5 and V8 would not let R2 go to bed that night and they were bullying R2. V8 stated telling V1 that V9 told V5 and V8 to keep R2 up out of the bed. V8 confirmed R3 was also sitting in the dining room at some point during the night and gave V1 the same statement R2 gave V1.</p> <p>On 7/17/24 at 11:55AM, V9 (Former Nurse) stated V9 was terminated from the facility due to R2 accusing V9 of teasing R2. V9 reported R2 was hallucinating and saying things that weren't right that night. V9 denied calling a physician about this behavior or giving a PRN medication. V9 stated R2 was kept up in the wheelchair in the dining room all shift to be better monitored. V9 reported R2 did ask to go back to bed that night. V9 said, The resident felt humiliated I guess.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/17/24 at 1:33PM, V10 (Quality Assurance Nurse/ADON) stated V2 brought R2 to V10 due to R2 making allegations of abuse against staff. V10 reported that the way R2 was describing what happened R2 was acting like R2 was verbally abused. V10 stated R2 said the staff members being rude to R2 and mentioned R2's mother in a comment the staff made. V10 confirmed all three staff members were terminated. V10 stated V5 and V8 should not have been talking to R2 like that and V9 was terminated for not stopping them talking to R2 in that manner.</p> <p>On 7/17/24 at 3:15PM, V11 (Social Service Director) stated R2 is at risk for abuse due to R2 having a severe mental illness. V11 reported this would be considered abuse due to the manner in which the staff were speaking to R2.</p> <p>On 7/17/24 at 4:08PM, V1 stated V10 reported to V1 that R2 needed to tell V1 something concerning. V1 reported R2 told V1 that two night shift CNAs teased R2, laughed at R2, and made comments about R2's mom. V1 confirmed R2 also mentioned that R2 was not able to lie down to go to sleep that night. V1 said all three staff members were suspended and then terminated after the investigation was complete. V5 and V8 were terminated for mental abuse and V9 was terminated for not stopping V5 and V8 from abusing R2.</p> <p>A Nursing note dated 6/24/24 at 6:39 AM documents R2 was alert and up through the night at times verbally abusive to staff and combative trying to get up from the chair. There is no other documentation that V9 provided any other interventions to R2 to help R2 calm down or called the physician.</p> <p>A Nursing note dated 6/27/24 documents allegations were made. The physician and family were also notified as well as the Administrator and Director of Nursing.</p> <p>A Social Service note dated 6/27/24 documents social services met with R2 for wellness check. R2 reported feeling OK. Social services was made aware that R2 made verbal abuse allegation against staff.</p> <p>The Abuse Risk Review dated 6/6/24 documents R2 is at risk for abuse due to serious mental illness, reduced social interactions, and frailty/total dependence. An updated abuse risk review was completed on 6/27/24 and R2 is still at risk for abuse for the above reasons along with being exposed to trauma.</p> <p>The Care Plan dated 4/8/24 documents R2 has been identified to be vulnerable for abuse due to a history of sexual assault and a diagnosis of substance use. The Care Plan dated 4/12/24 documents R2 is at risk for abuse due to a diagnosis of severe mental illness, diagnosis of substance abuse, history of sexual assault, history of allegations of verbal abuse by staff, and residing at a mental health facility. One of the interventions on this care plan document to report all instances of alleged abuse to the abuse coordinator as soon as possible.</p> <p>The Brief Interview for Mental Status dated 6/6/24 for R2 documents a score of 13 indicating no cognitive impairment.</p> <p>The Brief Interview for Mental Status Review dated 5/21/24 for R3 documents a score of 15 (no cognitive impairment).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The employee files for V5, V8, and V9 were reviewed. V5 and V8 completed abuse and sexual abuse training on 12/1/23. V9 completed the abuse and sexual abuse training on 1/21/24. The Termination Report dated 7/2/24 for V5 and V8 document the employees were notified of the termination via phone on this day. Termination is based on the investigation of the abuse allegation made by a resident on 6/27/24. The reason for termination documents physical or verbal abuse, neglect, or attempting to injure a resident or another person, including any other staff member, supervisor, or manager. The Termination Report dated 7/2/24 for V9 documents the employee is discharged after investigation of abuse. The investigation provided account of lack of supervision of the CNA ' s during the shift and failure to follow policy and procedure.</p> <p>The policy titled, Resident Rights, dated 12/2016 documents, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy interpretation and implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights might include the resident right to: a. a dignified existence; b. to be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation . The policy titled, Illinois Abuse Prevention Policy, dated 10/24/2022 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility, therefore, prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents . Definitions: Abuse means any physical or mental injury, or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident .Mental abuse includes, but it ' s not limited to humiliation, harassment, threat of punishment or deprivation .Staff Supervision: Supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur . Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observed, hear about, or suspect to the administrator immediately or to an immediate supervisor, who must then immediately report it to the administrator or to a compliance hotline or compliance officer .</p>		