STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145901	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEMONT NURSING & REHAB CENTER	**12450 WALKER ROAD LEMONT, IL 60439**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview and record review, the facility failed ensure that functioning call lights/call bells are available or within reach for residents who receives assistance with activities of daily living care. This applies to 5 of 8 residents (R2, R8, R9, R10, R11) reviewed for call light/call bell and activities of daily living (ADL) care in the sample of 11. The findings include: On 7/29/20 at 12:45 PM, R5 who is alert and oriented according to his most recent Minimum Data Set (MDS), stated that the facility's call has not been working and the facility provided the residents with call bell. 1. On 7/29/2020 at 12:50 PM R11 was sitting on her wheelchair which was positioned at the right side of her bed. R11's call bell was on top of her television stand which was located at the foot of her bed. The call bell was about 7 feet away from R11. 2. On 7/29/2020 at 12:55 PM R10 was sitting on her wheelchair which was parked at the foot of her bed. R10's call bell was on top of her bedside vanity table which was far behind R10. When asked if she could reach it R10 attempted to propel her wheelchair but was unable to. 3. On 7/29/20 at 1:05 PM, R8 was resting in bed leaning on her left side against the left upper side rails. R8's call bell was on top of her rolling table which was parked at the right side of her bed. R8 attempted to reach the call bell and stated that she could not reach it. 4. On 7/29/20 at 1:10 PM, R2 was lying in bed, there was no call bell insight. 5. On 7/29/2020 at 1:25 PM, R9 was resting in bed, stated I don't know where my call bell is. On 7/29/2020 at 2:40 PM, V1 (Administrator) that the call light in the facility's second floor unit is being fixed and the residents were provided call bells. The residents should have a call bell available and within reach. Facility's Policy and Procedure for Call Light/Call Bell showed: The purpose of this procedure is to respond to resident's request and needs. Procedure: - When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure an employee did not have contact with residents after an allegation of abuse and failed to report allegations of abuse to the abuse coordinator as per the facility's abuse policy. This applies to 1 of 3 residents (R3) reviewed for abuse from a total sample of 11. The findings include: The EMR (Electronic Medial Record) indicates that R3 was admitted to the facility in November of 2017 with numerous [DIAGNOSES REDACTED]. R3 was discharged to the local hospital on June 26, 2020 and did not return to the facility. R3's MDS (Minimum Data Set) dated May 30, 2020 codes R3 as needing extensive assistance for toilet use and transfers and R3 was totally dependent on staff for bathing. R3's care plan dated May 24, 2020 document R3's attention seeking behavior and delusions and making false reports of staff mistreatment. One care plan intervention dated May 24, 2020 documents, Staff will provide care in pairs. V13 (R3's daughter and Power of Attorney) was interviewed on July 2 at 11:42AM and stated that on June 24, 2020 R1 reported to her that the nurse aide had hurt her. R1 told her daughter that the nurse aide took the phone out of her hand and turned off the lights. V13 went on to add that V4 (Nurse) gave R1 back her phone so she could call her family member back. V4 told me that she called the administrator to notify him of the incident and that the nursing aide involved in the incident would not be taking care of R3 again that night. V9 (Certified Nurse Aide) was interviewed on July 2, 2020 at 12:04PM and on August 5, 2020 at 1:39PM about the incident. V9 stated she was providing personal care to R3 when the resident attempted to hit her and tried to tip the bedside table on V9. V9 stated that she reported the problem to V4 (Nurse) and V9 added that R3 reported to V4 (Nurse) that I hurt her and attempted to choke her with the cord. According to V9, R3 can be paranoid and hallucinate. Sometimes R3 wakes up in the middle of the night and claims there is a man or woman in her room trying to attack her. V9 also stated that she worked the rest of the shift but did not provide care to R3. V9 stated that she did not hear anything about the incident until Saturday (June 27, 2020) when V9 was told she could not return to work until the investigation was complete. V4 (Nurse) was interviewed on July 2, 2020 at 12:39PM and stated that V9 had come to her about R3's combative behavior. V4 reported that when she went into R3's room, the resident kept saying, Call the police, call the police. That woman did it. R3 was pointing to a small bruise on her hand and V4 stated that she measured it to be about 1.0cm by 1.5cm. V4 went on to add that she called V2 (Assistant Administrator) and informed him of the incident and V2 reported that he would look into it. V4 confirmed that V9 worked the rest of the night. V7 (Nurse) charted in the medical record, that woman who kept coming in and out did this referring to the bruising to the left hand. V7 also charted that the advanced practice nurse (NP) was notified and x-rays were ordered. V7 was interviewed on July 6, 2020 at 12:39PM and verified that she was aware of R3's complaint that someone had hurt her hand and that she was not told that this incident was being investigated as abuse issue. V2 (Assistant Administrator) was interviewed on July 6, 2020 at 3:58PM and stated that he did not suspend V9 because he perceived the situation to be a customer service issue. V2 stated he was not aware of a potential abuse issue until June 26, 2020 when the local hospital reported abuse to the facility. V3 (Director of Nursing) was interviewed on July 6, 2020 at 2:58PM about the incident with R3. V3 said that she that she dated the report June 26, 2020 because that was the date the local hospital informed her of the allegations. V3 went on to add that no one at the facility reported this to her or V2 (Assistant Administrator). V3 added that the staff should report abuse allegations to V3 or V2 immediately. V3 also denied knowledge of V7 (Nurse) documentation of R3's alleged abuse. A review of the facility's incident report indicated that this incident was not reported to the state health department until June 26, 2020 at 9:30PM in which the facility charted, While R3 was admitted to the local hospital on [DATE], R3 stated to hospital staff that the aide at the home assaulted her. A review of the hospital records dated June 26, 2020 documents R3's claim that a healthcare worker assaulted her and attempted to wrap the call light around R3's neck. The hospital record also documents that R3 claims that staff threatened to break all of her fingers. The facility's Abuse Prevention Policy dated February 2017 shows: V. Internal Reporting Requirements and Identification of Allegations. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploration, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Reports will be documented, and a record kept of the documentation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. VI. Protection of Residents Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pain reliever as ordered and failed to follow guidelines to ensure pain reliving medication was re-ordered to continue pain control. This applies to 1 of 5 residents reviewed for pain in the sample of 11. The findings include: R1 is an [AGE] year-old who has multiple medical [DIAGNOSES REDACTED]. R1 has chronic pain and he has been taking the [MEDICATION NAME] for several years. On 8/6/2020 at 3:27 PM, R1 stated that he uses [MEDICATION NAME] for pain even before he got admitted from the facility. R1 added, that there were times that he has been asking for pain reliever and they would tell him it's not due yet. R1 was unable to recall the exact dates of when he kept asking for his pain reliever. Review of R1's Medication Administration Record [REDACTED]. The April MAR indicated [REDACTED]. On 9/10/2020 at 10:42 AM, V3(Director of Nursing) confirmed that the [MEDICATION NAME] doses was not given on 4/11/20, 4/12 and 4/13. It needed renewal of prescription; the physician was notified. The physician had to call the pharmacy to renew the prescription since he had to give his DEA number to them. V3 was not sure what happened why it took 3 days for the [MEDICATION NAME] to be delivered. V3 added, facility has floor stock of [MEDICATION NAME], but it can't be accessed without a code from the pharmacy and without a script.