STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANDMARK OF RICHTON PARK REHAB & NSG CTR	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on interview and record review, the facility failed to follow their Abuse Prevention Policy, and prevent the physical attack of two of eight residents (R6 and R8) reviewed for physical attack. This failure resulted in R6 being slapped in the face by a co-peer, and R8 being hit in the head with a cane by a another resident. Findings Include: R6 is a [AGE] year old with the following Diagnosis: [REDACTED]. R7 is a [AGE] year old with the following Diagnosis: [REDACTED]. R8 is a [AGE] year old with the following Diagnosis: [REDACTED]. R10 is a [AGE] year old and admitted to the facility on [DATE]. An Incident note, dated 7/1/20, documents R10 was the recipient of physical aggression by a co-peer. Both residents were separated and counseled on the rules of conduct at the facility. The Incident Report, dated 7/1/20, documents R10 accidentally rolled over R8's foot while exiting the elevator, and R10 alleged R8 hit R10. A police report was filed. The Hospital Records, dated 7/1/20, document R10 visited the hospital for a [MEDICAL CONDITION] and apply an antibiotic ointment to the area until healed. The Care Plan, dated 11/22/19, documents R10 is at risk for neglect or abuse due to behavioral symptoms are R10 have difficulty managing. A Nursing note, dated 8/10/20, documents R7 initiated physical contact with R6 while walking past the nurse's station. R7 refused to give a description of the incident. Both residents separated and an assessment was performed but no injuries noted. The Incident Report, dated 8/13/20, documents R7 made physical contact with R6. No injuries noted and staff separated both parties immediately. R7 placed on behavior monitoring. R6 reported feeling safe in the facility. No further issues noted between R6 and R7. On 8/19/20 at 11:04AM, V4 (Smoke Break Monitor) stated, R10 is very boisterous and will tell you exactly what is on R10's mind. I know R10 said something to R8 and R8 hit R10 with R8's cane on the back of R10's head. It was on the fourth floor I don't know where it happened but I know it was on the 4th floor when they were both COVID positive. I think R10 was sent to the hospital but I don't know if he needed staples or not. R10 does have aggressive behaviors when R10 doesn't get his way. I think we just monitor R10. You can't really tell when R10 is going to get upset. This would be considered physical abuse. On 8/19/20 at 12:39PM, R6 stated, I was talking with the nurse at the nurse's station about my sub sandwich I got when I got slapped in the face out of nowhere by R7. It was for no reason. I didn't say anything to R7 or even look at R7. R7 just slapped me hard in the face. It was with an open hand. I wasn't hurt but my face was on fire for a little bit. It was burning. On 8/19/20 at 12:53PM, R10 stated, I forgot who it was but I was hit in the head with a cane and had to go to the hospital to get my head sewed up. I had to get 2 staples. I was opening the door of the room and R8 swore I grabbed it from R8 so I told R8 to cut it out and that's when R8 hit me in the head with a cane. The one lady saw and got R8 out of there away from me. The nurse checked me out and I had to go to the hospital. Nothing else was wrong with me besides that. On 8/19/20 at 1:04PM, R8 stated, Yea, I hit R10 in the head with my cane. R10 was talking smart to me and went at me so I hit him in the head. R10 tried to hit me in the face. I was standing and R10 was in a wheelchair and R10 tried to hit me. They separated us and that's it. Surveyor attempted to speak with R7 about this incident involving R6, but R7 refused to talk with the surveyor. On 8/19/20 at 1:25PM, V1 (Administrator) stated, When we have an instance of abuse, we separate the residents immediately and make sure no one is hurt. The nurse will do vital signs and an assessment. I get notified by the staff and start the reportable. Usually the person who was the first to hit gets put on one to one monitoring. They are on that until they can calm down and if they can't then the doctor sends them out to the hospital We may give them a PRN medication too if they have one ordered. They chart on the one to one monitoring for 72 hours. If they are in the same room one person gets moved to another floor when one is available. We also call 911 and make a police report. I always talk to both residents and make sure they feel safe afterwards. On 8/19/20 at 4:19PM, V7 (Social Worker) stated, R10 does have behaviors of yelling out and cussing at people but nothing physical. We have monitoring for behaviors for the residents from everyone during the day. We have a social worker assistant go around and do behavior checks starting at 7am and the last round is at 10pm. The nurses and CNAs monitor the behaviors overnight. We put in new interventions after behaviors so we can monitor the behaviors to prevent any outbursts against other residents. R10 was told to not put his hands on other residents to talk about situations with his peers with staff to handle them. On 8/19/20 at 4:27PM, V8 (Nurse) stated, I was sitting at the nurse's station talking to R6. R7 was just walking around the nurse's station and slapped her in the face. We were both kind of shocked. No, R6 never said anything to him. He was put on one to one monitoring immediately and was talked to by social work. I don't know of any other issues with R7 and R6. When I see them in the hall or near each other they just don't talk to each other. I don't remember why R7 said he did that. I called the manager right away. It would be physical abuse. The Abuse Prevention Policy, dated 1/2019, documents, For the purpose of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. . 4. Physical Abuse: hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

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.