STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145629	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE MANOR NRSG & REHAB CTR	**345 DIXIE HIGHWAY CHICAGO HEIGHTS, IL 60411**

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 observation, interview, and record review, the facility failed to keep two of three residents (R2 and R13) free from verbal and mental abuse by staff treating cognitively impaired residents in a disrespectful manner; staff posted video of resident (R2) on social media and spoke to (R13) in a patronizing manner. This deficiency resulted in R13 crying out and exclaiming that she was disrespected. Findings include: R2 has [DIAGNOSES REDACTED]. R2's cognition is severely impaired. Facility reported investigation documented event on 6/23/20 at 12:45 pm. Description of occurrence is that R2 and V3 (Certified Nursing Assistant, CNA) were in a verbal altercation that was recorded by V3 and posted on social media. R2 was shown going through V3's lunch bag. V3 verbally redirected R1 to keep her hands off her food. R1 walked away at that point. Resolution noted that the investigation was completed. V3 was relieved of her position prior to the facility being made aware of the video because she did not complete CNA test within 120 days of hire. R2 has no injuries or signs or symptoms of distress. V1 (Administrator) notified, police were not notified. In services done on 6/23/2020 by V13 (Social Worker) to staff note topic of Social Media/Abuse. This includes social media policy that states to NEVER share pictures or videos of residents on ANY form of social media. Typea of Abuse include Mental Abuse and Verbal Abuse which is the use of oral, written, or gestured language that willfully includes disparaging and derogatory term to resident or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. On 8/19/20 at 3:34pm, V1 (Administrator) stated that on 6/23/20, another facility called and told me there was a resident of ours on social media. He sent me the video and you could see it was R2. She was going through V3's (CNA) lunch bag who was not real pleasant, and said, What do you think you are doing? R2 walked away. This was after mealtime and I could not see anyone else in the video. I could not see V3 but heard her voice. There was no abuse. I am not sure who posted it or when it was taken as there is no date on the video. When I tried to open it and look again, it was gone. I contacted R2's daughter and informed her that it was no longer viewable. R2 didn't have any idea it happened. It was not posted the day it occurred though. When I came in on 6/23/20, V3 was not working. She was let go on 6/24/20 because she didn't take the CNA test within the 120 days per policy. R2 had no recollection of anything. We did staff education that day. I did not talk to any other staff or residents. The police were not notified. This is a type of abuse at the facility because they thought it was funny that a person would rummage through her lunch. I wanted staff to know abuse is not just financial or physical, putting a photo or video on social media of R2 is abuse at this facility because V3 thought it was funny. On 8/20/20 at 11:04 am, V1 (Administrator) stated that I did not interview other staff or residents in an abuse investigation. I guess I did not take it as abuse. I just took it as inappropriate. The abuse policy states it is abuse. I did not see V3 on the recording, I just heard her voice. I believe it was V2 (Director of Nursing, DON) who recognized her voice. On 8/20/20 at 1:40pm, V13 (Social Worker) stated that R2's assessment notes she is at risk for abuse and neglect and has dementia. I do not know if there an incident but I was asked to do an in-service regarding social meeting posting on 6/23/20. It included information on videotaping and social media posting. If anything with a resident is posted on social media by a staff, it is an abuse situation. If there was an incident reported to me, I would check in with the resident. I did not get report of any abuse allegations with R2 in June or regarding social media posts. On 8/24/20 at 10:52 am, V2 (Director of Nursing, DON) stated V1 informed me of the video on social media with R2 and I was able to see the video with R2 and V3 before it disappeared. I saw R2 going through a lunch bag. I could see that V3 (CNA) told her do not go through that and it doesn't belong to her. I was told by V1 that that V3 was no longer employed at the facility unrelated to this incident. R2's Abuse risk assessment and care plan note R2 is at risk for abuse. Interventions include to provide a calm environment and remove her from potentially volatile environment when observed. R2 is alert and has decision making and memory impairments due to dementia. R2 wanders in hallway and into other resident's rooms. Interventions also include when she becomes socially inappropriate, to provide comfort measures. R13 has a [DIAGNOSES REDACTED]. On 8/20/20 at 11:20am, R13 was heard raising her voice and agitated in the dining room. V11 and V12 (activity aides) were in the dining room as well. V11 and R13 heard talking back and forth and R13 was agitated and upset. When surveyor moved closer to the dining room, R13 asked V11, What did you say and where do you live? V11 answered rudely and pointedly, I wasn't talking to you. I'm not from around here. R13 became more upset and stated that she would have her family find out. V 11 stated, no you won't in a taunting manner. R13 raised her voice again crying out, you can't talk to me like that, where do you live? I can ask someone to find out. V11 stated, No you won't! And that's none of your business! R13 began crying very loudly and kept saying, you don't have to talk to me like that and disrespect me. V12 (activity aide) saw surveyor and left the room. Surveyor approached V11 who suddenly lowered his voice and spoke calmly and quietly to R13 who was still crying and yelling. V7 (Licensed Practical Nurse, LPN) entered the dining room and asked R13 what is wrong? R13 was still yelling and crying, stating that V11 didn't have to talk to her like that and he is disrespecting me. R13 threw her mask on the table in front of her as V7 took R13 to her room, still yelling and crying. On 8/20/20 at 11:23am, V11 stated that R13 has dementia and I know her very well. She gets upset all the time and we are supposed to talk calmly to them and just reassure them because this is their home. If that does not work, then we are supposed to get the nurse. Surveyor informed him I heard the conversation that just happened and he stated that I know her really well and she just gets like that. She won't even remember if I ask her right now. I got abuse training when hired which includes the different types of abuse. On 8/20/20 at 11:27 am, V12 (Activity Aide) stated that he was in the room with V11 when he was talking back and forth with R13. V 12 stated that she has dementia and there is no use arguing with her like that because she will keep going and gets more upset. On 8/20/20 at 11:34 am, V7 came out of R13's room and stated she went into the dining room because she heard R13 yelling that someone disrespected her and was crying. V7 stated I asked her what happened and she told me that she asked V11 (activity aide) a question and he started talking rudely to her and disrespecting her. V7 stated, she knows V11 and told me his name. On 8/20/20 at 1:15pm, V1 (Administrator) stated that V7 informed me that there was an incident with V11 and R13. I sent V11 home and interviewed V7 and V12. I did an investigation and sent it to public health. V7 told me that R13 was yelling and crying so she took her to her room and asked her what happened. I sent him home after doing an in-service regarding customer service. V7's's progress note dated 8/20/20 states she responded to R13 telling at staff in the dining room. Upon entering the room, she was tearful and stating, He disrespected me! R13 identified V11 (activity aide) and stated that he was conversing with another resident when she asked what did he say and his replay was I wasn't talking to you (stated residents last name). I just wanted to know what they were talking about and he didn't have to disrespect me like that. Care plan dated 4/23/20 notes R13 has behaviors of yelling and interventions that list provide a calm environment, maintain a calm, slow and understandable approach. Facility abuse policy dated February, 2017 states the facility affirms the right of our residents to be free from verbal, mental abuse and exploitation, which includes but is not limited to humiliation. This facility therefore prohibits

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) abuse, and mistreatment of [REDACTED]. Types of abuse include Verbal abuse which is the use of oral language that willfully includes disparaging and derogatory terms to the residents regardless of an individual's age, ability to comprehend or disability. Mental abuse includes humiliation. Establishing a resident sensitive environment. Photographing and recording residents or their private space for other than medical or facility purposes as described in a signed Audio, Video and Photographic Release Form is strictly prohibited. Staff posting or sending a phone or recording on social media is strictly prohibited. Staff talking or using a recording of a resident in a manner that demeans or humiliated a resident, regardless of the resident's cognitive status or whether the resident consented, is strictly prohibited and will be handled as an allegation of abuse in accordance with the procedures set forth. Staff includes employees. Recording includes taking photographs or recordings from any type of device, including smart phones. Protection of rights states residents shall be immediately evaluated to determine suitable therapy, care approaches.
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 interview and record review, the facility failed to follow their abuse policy for one resident (R2) by not conducting and reporting an abuse investigation related to a staff member posting an unauthorized video of the resident on social media. Findings include: R2's [DIAGNOSES REDACTED]. Her cognition is severely impaired. Facility reported investigation documented event on 6/23/20 at 12:45 pm. Description of occurrence is that R2 and V3 (Certified Nursing Assistant, CNA) were in a verbal altercation that was recorded by V3 and posted on social media. R2 was shown going through V3's lunch bag. V3 verbally redirected R1 to keep her hands off her food. R1 walked away at that point. Occurrence Resolution noted the investigation was completed. V3 was relieved of her position prior to the facility being made aware of the video because she did not complete CNA test within 120 days of hire. R2 has no injuries or signs or symptoms of distress. V1 (Administrator) notified, police were not notified. In services done 6/23/200 by V13 (Social Worker) to staff with topic of Social Media/Abuse. This includes social media policy that states to NEVER share pictures or videos of residents on ANY form of social media. Type of Abuse include Mental Abuse and Verbal Abuse which is the use of oral, written, or gestured language that willfully includes disparaging and derogatory term to resident or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. On 8/19/20 at 3:34pm V1 (Administrator) stated that on 6/23/20, another facility called and told me there was a resident of ours on social media. He sent me the social media video and you could see it was R2. She was going through V3's (CNA) lunch bag who was not real pleasant, and said what do you think you are doing? R2 walked away. This was after mealtime and could not see anyone else in the video. I could not see V3 but heard her voice. There was no abuse. I am not sure who posted it or when it was taken as there is no date on the video. When I tried to open it and look again, it was gone. I contacted the R2's daughter and that it was no longer viewable. R2 didn't have any idea it happened. It was not posted the day it occurred though. When I came in on 6/23/20, V3 was not working. I looked at the schedule to see when she worked last to check the timeframe. I did not speak to any other residents or staff regarding this incident. V3 was let go on 6/24/20 because she didn't take the CNA test within the 120 days per police. R2 had no recollection of anything. We did education that day to staff that were working that day. The police were not notified. This is a type of abuse at the facility because they thought it was funny that a person would rummage through her lunch. I wanted staff to know abuse is not just financial or physical, putting a photo or video on social media of R2 is abuse at this facility because V3 thought it was funny. On 8/20/20 at 11:04am, V1 (Administrator) stated that I did not speak/interview any other staff or residents. I guess I did not take it as abuse. I just took it as inappropriate. The abuse policy states it is abuse. I did not see V3 on the recording, I just heard her voice. I believe it was V2 (Director of Nursing, DON) who recognized her voice. On 8/20/20 at 12:45pm, V10 (Human Resource Director) stated that V3 (CNA) was hired on 5/22/20 was terminated on 6/24/20 after being advised V3 did not pass the CNA test as required. There are no disciplinary action or abuse allegation on file from facility and I am not aware of any allegations. On 8/20/20 at 1:40pm, V13 (Social Worker) stated that R2's assessment notes she is at risk for abuse and neglect and has dementia. I do not know if there an incident but I was asked to do an in-service regarding social meeting posting on 6/23/20. It included information on videotaping and social media posting. If anything with a resident is posted on social media by a staff, it is an abuse situation. If there was an incident reported to me, I would check in with the resident. I did not get report of any abuse allegations with R2 in June or regarding social media posts. On 8/24/20 at 10:52 am, V2 (Director of Nursing, DON) stated that I was able to see the video with R2 and V3 before it disappeared. I saw R2 going through a lunch bag. I could see that V3 (CNA) told her do not go through that and it doesn't belong to her. It looked like it was filmed during the day and was in one of the dining rooms. I could not see anyone else around. I was told that V3 was no longer employed at the facility related to something else when the video was posted. Facility abuse policy dated February, 2017 states the facility affirms the right of our residents to be free from verbal, mental abuse and exploitation, which includes but is not limited to humiliation. This facility therefore prohibits abuse, and mistreatment of [REDACTED]. Types of abuse include Verbal abuse which is the use of oral language that willfully includes disparaging and derogatory terms to the residents regardless of an individual's age, ability to comprehend or disability. Mental abuse includes humiliation. Internal reporting: Employees are required to report any incident they observe, hear about or suspect to the administrator immediately. The appointed investigator will at a minimum attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any pertinent medical records or other documents will be reviewed. Residents to whom the accused has regularly provided care and employees with whom the accused has regularly worked, will be interviewed and a summary will be used for reporting purposes. The allegation will result in an internal investigation. If the allegation is determined to be valid and the perpetrator is an employee, written evidence will be kept in the employee file. The Local Law Enforcement should be contacted when there is a reasonable suspicion that a crime has been committed in the facility by a person other that a resident. If it does not involve seriously bodily injury, then a report to local law enforcement as soon as possible but within 24 hours of when the suspicion was formed.