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Silenced: Residents' Fear of Retaliation in 40 Nursing Homes in Illinois

Summary of 42 State Investigation Reports

By Eilon Caspi PhD

Gerontologist

eiloncaspi@gmail.com

Illustration by Yuval Caspi

Report prepared for Alliance for Community Services

Quotes

"*I was definitely scared. You don't know what will happen when I am alone with her*"

The CNA told me: "*I was going to get this d**n dialysis done or she was going to kick my a**"*

He didn't want to talk much about being sexually abused because the CNA "*is a tall strong guy and he is a sickly person who cannot defend himself*"

"*I fear for my life if she loses her job. Like a postal worker, she'd come back and shoot me. I don't want to get anyone hurt. I'd try to fight her. I'd lose but I won't be silent. She scares me, and I can't do anything about it*" | A Licensed Practical Nurse said that the CNA "*going into* [the resident's] *room was like throwing gasoline onto a fire*"

"*What am I supposed to do when you leave? I still must live here. I don't want to talk anymore*"– Resident to state surveyor

"*I just ignored her because based on something I say, the staff will stick me with needles and send me out to the hospital*"

"*I was worried that she would try to kill me by overmedicating me*" | "*I feared for my life*"

The CNA "*was the epitome of fear of someone who is blind without legs*"

"*I didn't tell anyone [about the abuse] because I was afraid [the CNA] was going to retaliate*"

"*I was scared of her. I was scared she was going to hit me*"

"*She was having nightmares and was scared to use her call light when [the CNA] was working, so she just peed the bed*"

Not asking for a shower because "*she could have hit me*" | "*I was afraid of her. It was trauma*"

"*I'll go break all your things Mother fucker*" – CNA becoming abusive after not locating scissors the CNA loaned to the resident for an art project

When a resident asked a CNA to stop spraying air freshener in her bedroom, the CNA said: "*Don't you ever tell me how to do my job*." The resident felt threatened, unsafe, and got scared "because [the CNA] is "*a big guy yelling at a little person like me*"

"*The minute you challenge her* [CNA], *she runs to whoever is in charge and makes up stuff and that starts a fire*"

"*She was on the war path that morning, so I just tolerated her*"

CNA said to resident with severe cognitive impairment: "*If you hit me, I will have you sedated*"

Referring to a Registered Nurse who put her call light out of reach (for "*pressing the call light a lot*"), the resident said that the nurse "*is keeping me prisoner, he is holding me captive*"

"*I was yelling for help*. [CNA] *came in my room and said, "What do you want? Shut up!" Then all of a sudden, "BAM, BAM, BAM," he punched me in the mouth three times. It hurt like heck*"

CNA kicked "*really hard*" the wheelchair of a resident with moderate cognitive impairment because the resident left their bedroom with no clothes on

Resident after alleged physical abuse: "*I was so afraid; I didn't sleep the rest of the night*"

CNA to resident with dementia who was trying to masturbate: "*Put it away or I will cut it off*"

A Registered Nurse scolded a resident with Parkinson's disease for getting out of bed without using her call light. The RN threatened to send her to the E.R. for not listening. The Director of Nurses told the RN: "*Scaring someone to death is not the way to do it"* (use the call light)

While trying to forcefully put pants on a resident with dementia (receiving hospice services), CNA 1 grabbed the resident's bed remote and hit the resident in the stomach and on the knuckles. CNA 1 then called the resident "*Mother f****r*" and told CNA 2:

'Do not let the residents walk all over you. You have to show them some discipline'

While speaking with a state surveyor, a resident fearful of retaliation from a new Administrator who verbally / mentally abused her said:

"*Don't mention my name, because I'm afraid of her*"

The resident added:

"*I don't know how much longer I can take this.*

We have freedom of speech in America"

Table of Contents

Acronyms

ADL – Activities of Daily Living

BIMS – Bried Interview of Mental Status

CNA – Certified Nursing Assistant

FOIA – Freedom of Information Act

LPN – Licensed Practical Nurse

LTCOP – Long-Term Care Ombudsman Program

MDS – Minimum Data Set

RN – Registered Nurse

Definitions

*__Fear__ is defined as 'an unpleasant often strong emotion caused by anticipation or awareness of danger.'
**__Fear of retaliation__ is defined as 'a concern or feeling of vulnerability that one's actions may cause retaliation by another.'
**__Retaliation__ is defined as 'an actual or perceived negative reaction of a person as a result of another person's action or behavior.'
***__Retaliation__ is also defined as 'acts of retaliation / revenge by facility staff in response to complaint to the facility, Ombudsman program, or state survey agency.'
* Merriam-Webster Dictionary ** Voices Speak Out Against Retaliation's Instruction Guide *** National Ombudsman Reporting System – Complaint Code D06

Introduction

Residents' complaints in nursing homes are considered 'the front-line system for addressing their concerns' (U.S. Office of Inspector General, [OIG] 2006) and 'a critical safeguard to protect vulnerable residents' (OIG, 2017). However, research has found that 23% of nursing home residents worry about retaliation when voicing care concerns. It also found that "worry about potential retaliation was just as fearsome for some individuals as the experience of retaliation itself" (Robison et al. 2007; 2011).

In addition, Kristine Sundberg, Executive Director, Elder Voice Advocates in Minnesota stated recently, "*We constantly hear about retaliation fears and actual harm to residents, families and staff. This is a rapidly escalating problem that results in inconceivable suffering, and it must be stopped*."

A recent report titled *They Make You Pay: How Fear of Retaliation Silences Residents in America's Nursing Homes* (Long Term Care Community Coalition, 2023) – based on a study in 100 nursing homes in 30 states – identified serious emotional and physical consequences on residents experiencing fear of retaliation, threats of retaliation, and actual retaliation (Caspi, 2024a). The study showed that fear of staff and managers' retaliation represents a strong barrier for reporting and investigating rights violations, care concerns, neglect, and abuse.

In accordance, the National Long-Term Care Ombudsman Resource Center (2018) stated, "Fear of retaliation is one of the most common reasons residents do not want to pursue a complaint and disclose their identity." Related to it, investigative journalist Chris Serres (2017a) wrote, "The threat of retaliation not only terrifies residents…, it discourages them and their families from taking steps that would protect their rights or enforce public regulations."

The study by Caspi (2024a) has generated overwhelming evidence demonstrating the gross asymmetry of power that often exists between residents and staff/managers. Physically dependent on staff for meeting their basic care needs, many residents remained silent to avoid retaliation. They continued to suffer while their care was neglected and/or when they were verbally and/or physically abused. Many perpetrators and care providers were not held accountable for their acts (such as retaliatory neglect and abuse) and residents were sometimes forced to continue and receive care from perpetrators or see them in the care home when they were not immediately suspended pending investigations.

Background on Current Project

The Alliance for Community Services commissioned a report on residents' fear of retaliation and actual retaliation when voicing care concerns in Illinois nursing homes. The project started on October 21, 2024. A total of 42 state investigation reports from 40 nursing homes served as the basis for this report (the reports were retrieved primarily from Nursing Home Inspect (ProPublica) website but also from a CMS dataset received through a FOIA request). Each investigation report was reviewed and summarized to shed light on residents' lived experience of fear of retaliation, threats of retaliation, and actual retaliation against them. The summaries are presented here (pages 4 to 47) followed by a discussion including practical and policy implications (pages 48-50).

Case 1 – Fear of Retaliation After Being Mentally / Verbally Abused

The nursing home failed to: a. Ensure a resident was free from mental/verbal abuse. **The failures resulted in** psychological harm expressed as **fearfulness** when discussing an incident when staff yelled at her (R10). b. Protect residents by immediately suspending an employee accused of abuse, pending the outcome of an investigation. As a result of this failure, R10 was exposed to an alleged abuser V3 (Social Services Director) while V3 was under investigation for abuse. c. Thoroughly investigate an allegation of abuse.

R10 diagnoses included, among others, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease with exacerbation, acute diastolic congestive heart failure, hypertension, Type 2 diabetes, anxiety disorder, major depression, peripheral vascular disease, morbid obesity. R10 used a wheelchair. R10 was "**moderately impaired" in cognition** (based on MDS assessment).

R10 stated she discussed a problem regarding her wheelchair with the Administrator (V1). She told V1: "I'll believe it when I see it" and that Social Services Director (V3) began arguing with her (R10) accusing her of calling V1 a liar. R10 became upset, left the office, and went to her bedroom.

R10 stated:

> When she got to her bedroom, she received a call from her daughter asking why she called V1 a liar. R10 stated V3 called her daughter and accused R10 of calling V1 a liar. She said she never called V1 a liar and became very upset at V3 for calling her daughter. R10 stated V3 then came to her bedroom as R10 was sitting on her bed. R10 stated V3 stood in front of R10 and **R10 told V3 she did not want to talk to her**. R10 stated she told V3 to get out of her bedroom and **R10 put her hands over her ears because she did not want to hear or speak to V3.** R10 stated V3 then **put her hands over R10's hands and squeezed R10's hands onto her head**. R10 stated V3 went on and on yelling after R10 told V3 she did not want to talk to her. So R10 decided to leave her bedroom. V3 kept yelling, "Stop! I am not finished talking to you!" R10 stated she "**felt scared** when V3 put her hands over her (R10's) hands and **squeezed her ears**." R10 stated she told V3 to, "Stop, I got my glasses on." R10 stated V3 was "**pushing the frame of her glasses into her temples**." R10 stated there was nobody around and R10 did not want to be around V3 by herself. R10 stated she was uncomfortable around V3 **and she was concerned what would happen when she was alone with V3.** R10 stated V3 "can come down hard."

R10 stated, "**I was definitely scared**….I'm [AGE] years old in a wheelchair and I don't know what can go on. **You don't know what will happen when I am alone with her."** R10 stated **she told V1 (Administrator) she was afraid of V3** and R10 was told to go directly to V1 with any of her concerns.

Name of Nursing Home	Abbington Vlge Nrsg & Rhb Ctr
Provider Identification Number	146065
Address	31 West Central, Roselle, Illinois, 60172
Investigation Completed	June 13, 2022
Deficiency Citations Issued	F600, F610

Case 2 – Fear of Retaliation After Threat to be Fed Cat Food

The nursing home's failure to prevent abuse resulted in R1 being verbally and mentally abused by a former cook (V3).

R1 said she did not receive her dinner tray and she informed staff about it. R1 was told it was better for her to go to the kitchen to get her food, so that she can tell the kitchen staff what she wanted. R1 said she went and got the Psychiatric Rehabilitation Services Coordinator (V9) to take her to the kitchen. R1 said they found Former Cook (V3) in the kitchen and V9 asked her for R1's dinner tray.

R1 stated:

> V3 said she would not get R1 any food tray, and **if it was up to V3, she would feed R1 cat food then give R1 a sandwich.** R1 said V9 asked V3 what she (V3) had said, and V3 repeated that she would feed R1 cat food if it was up to her, then give R1 a sandwich. R1 said she and V9 left the kitchen without saying anything, and R1 said she **felt hurt, disrespected, and she felt like a nobody**, and felt like she was **treated like a child**. R1 said she **would not eat anything from the kitchen if V3 was still in the kitchen because** she was **scared V3 might feed her some bad food**. R1 said she did not eat that night because she **feared something bad might be put in her food.** R1 said she went and got a bag of potatoes to eat for dinner. R1 said she slept very upset, and she was hungry.

V9 stated she took R1 to the kitchen to get a sandwich after R1 said she was brought the wrong food than what she had ordered. V9 said **Former Cook (V3) gave R1 a regular sandwich, but R1 said she wanted a sub sandwich**. V9 said V3 got irritated by R1 and instead of V3 deescalating the issue, she escalated the situation by telling R1 that she (V3) would rather feed R1 cat food than give R1 a sub sandwich. V9 said at that point, she asked R1 to go back to the unit and escorted R1 back to the floor to prevent further escalation of the situation. V9 told V3 that she (V9) was going to inform the Administrator (V1) about the verbal exchange. She (V9) said that what V3 told R1 is **a form of verbal and mental abuse**. The Director of Nursing (V2) said V3 telling R1 that she (V3) would rather serve R1 cat food than make her a sandwich is **definitely verbal and emotional abuse**, and it could have had so many ramifications for R1, such as R1 refusing/**stopping to eat from the kitchen for fear of being served cat food.** The Administrator (V1) said more than likely the verbal abuse happened because a staff (V9) was present when the abuse happened.

Social Services Note: R1 met with V5 and reported she was verbally threatened by V3 around 6pm. V3's HR record indicated: V3 was suspended pending investigation for verbal and emotional abuse. Incident Report documented: Facility has evidence to support the allegation made by R1.

Name of Nursing Home	Austin Oasis
Provider Identification Number	145834
Address	901 South Austin Blvd. Chicago, Illinois, 60644
Investigation Completed	October 27, 2023
Deficiency Citations Issued	F600

Case 3 – Threat of Harm If Resident Refuses to Receive Dialysis Treatment

The nursing home failed to ensure R2 remained free from verbal abuse.

R2 diagnoses included, among others, chronic kidney disease, dependence on renal dialysis, and acute kidney failure.

R2 had "**memory problems**" based on Brief Mental Status Interview. That said, later the investigation report quotes Assistant Director of Nursing (ADON, V9) stating that R2 was "**alert and oriented**."

CNA (V7) escorted R2 for treatment at a dialysis center at a local hospital. R2 states R2 was in so much pain that V7 **told me** (R2) **"I was going to get this d**n dialysis done or she (V7) was going to kick my a**."**

Dialysis Nurse, RN (V8) stated that when V8 started R2's dialysis treatment, R2 began to complain of abdominal pain, discomfort with sitting in the dialysis recliner chair and asked for dialysis treatment to stop. V8 stated that V8 educated R2 regarding the consequences of not receiving R2's dialysis treatment and R2 still refused R2's dialysis treatment. R2 then signed the Against Medical Advice (AMA) form and V8 stopped R2's dialysis treatment and called EMT to transport R2 back to the nursing home. V8 then phoned the nursing home to inform R2's nurse of R2's refusal of the dialysis treatment.

V8 stated that when V8 returned to R2, V7 was yelling at R2 telling R2 that R2 better get R2's dialysis treatment and to sit up before R2 fell out of the dialysis chair. V8 also stated that several other staff members reported to V8 that V7 was yelling at R2 and being aggressive with R2 while V8 was on the telephone. V8 stated that V8 then asked V7 to step out of the dialysis clinic multiple times and V7 stated to V8 that V7 would step out because V7 was ready to fight.

V8 stated that the EMT arrived and transported R2 back to the nursing home and that V8 called the nursing home to report V7 verbal aggressiveness towards R2.

ADON (V9) interviewed R2 regarding the incident with V7 at the dialysis center. R2 stated that **R2 was scared of V7 and felt that V7 would harm R2**. V9 explained that R2 was in pain and did not want to receive dialysis treatment when V7 began yelling at R2, **"You are going to get this done or I'm going to kick you're a**."** V9 stated R2 continued verbalizing his **fears of V7 threatening to harm R2**.

The nursing home's final Reported Incident indicated: The facility does have evidence to substantiate the allegations made by R2.

Name of Nursing Home	Austin Oasis, The
Provider Identification Number	145834
Address	901 South Austin Blvd. Chicago, Illinois, 60644
Investigation Completed	January 4, 2024
Deficiency Citations Issued	F600

Case 4 – Fear of Reporting Physical Abuse to State Surveyor

The nursing home failed to follow its abuse prevention policy and to prevent incidents of staff to resident verbal and physical abuse. The failure affected R1 and another resident. **Registered Nurse (V4) yelled at R1, pulled R1's hair, and hit R1's arms**.

R1 is "**alert and oriented**" and "able to make needs known" (based on BIMS score of 13 out of 15).

R1 stated R1 **wanted to take a bubble bath**. R1 went to the nurse's station to get towels. R1 stated V4 was yelling at R1. R1 stated V4 came from behind the nurse's station, stood behind R1's wheelchair, and **pulled R1's hair and hit R1's arms** before staff came and took R1 to her bedroom.

Security (V7) stated that V7 heard V4 and R1 yelling. V7 stated V7 could hear V4 stating, 'If I count to 5 and have to get up,' then she heard V4 counting. V7 stated when V7 heard V4 say '5,' V7 got up immediately and ran towards the nurse's station. V7 stated she observed V4 with her **hand wrapped in R1's hair** and R1was **screaming and crying**. V7 stated R1 had a clip in her hair and V7 observed the clip dented / broken in R1's hair. V7 stated V9 (CNA) took R1 to R1's bedroom to fix R1's hair. Another CNA (V9) stated her hair appeared to have been pulled.

Psychiatric Rehabilitation Services Coordinator (V11) stated that R1 reported the incident to him. R1 showed V11 some **redness on R1's right arm** that resulted from the incident. V11 stated that R1 informed him that V4 grabbed the back of R1's neck and hit her arms.

CNA (V12) stated R1 informed V12 that R1 had an incident the night before. V12 stated R1 mentioned R1 was **scolded and yelled at**. V12 stated **R1 would not tell V12 the name of the staff member involved or any further details of the incident**.

LPN (V13) stated that when V13 did a wellness check on R1, **R1 "looked upset" but would not tell V13 what happened.**

When questioned by the state surveyor, R1 was observed to be **fearful to discuss the incident.**

While the incident occurred at 10:00pm, review of V4's timecard revealed that V4 did not clock out and exit the nursing home until 11:45pm.

Name of Nursing Home	Countryside Nursing & Rehab Ctr
Provider Identification Number	145798
Address	1635 East 154thh Street, Dolton, Illinois, 60419
Investigation Completed	May 11, 2023
Deficiency Citations Issued	F600

Case 5 – Fear of Retaliation After Rough Care

The nursing home failed to: a. Ensure residents are free from staff to resident abuse for R3. **This failure resulted in** R3, during care, experiencing physical pain and emotional distress with **continued feelings of intimidation, fear,** sadness, anxiety, and helplessness. b. Report an allegation of staff to resident physical and emotional abuse to the Department of Public Health and local law enforcement for R3. c. Immediately initiate and thoroughly investigate allegation of staff to resident abuse for R3.

R3's diagnoses included, among others, **quadriplegia**, morbid **Obesity**, and anxiety disorder. The resident has "**no deficits in cognition"** (based on MDS assessment) and is "**alert and oriented** to person, place, and time."

R3 was **tearful** and stated she had been **reluctant to speak to the surveyor**.

R3 stated:

> V5 and V6 (CNA) were providing incontinence care prior to showering. R3 stated that upon entering the room, V6 seemed to be short with her. R3 stated as V6 was rolling her to her side, R3's **flaccid left arm was caught under her body**, and due to Neuropathy, **she was in extreme pain**. R3 stated she **yelled for V6 to stop** because she was hurting R3, but **V6 did not stop** (V5 confirmed that V6 was not being careful and continued rolling R3 over despite R3 asking her to stop). R3 stated she was hollering and V6 was hollering right back at her. R3 stated when the mechanical lift sling was placed under her, V6 stormed out of the room and into the hall, yelling, "I can't do this anymore" and making statements about how uncooperative R3 is. R3 stated R3 "felt like (expletive)" and started crying because she thought R3 and V6 were friends.

R3 stated she **feels very scared** and vulnerable **because she can't move or take care of herself and is completely dependent on staff.**

R3 stated sometimes V6 is the only CNA working on the unit and **she is afraid if V6 is mad at R3**, **she might not go to tell other staff she needs help** or would not go in R3's bedroom if there was an emergency. R3 stated she **worries that V6's feelings about her will poison other staff's opinion of R3**. R3 stated **she had not wanted to tell the Surveyor this because she fears staff retaliation.**

In addition, CNA (V7) stated she witnessed V6 make racial slurs about R3 behind R3's back.

Name of Nursing Home	Doctors Nursing & Rehab Center
Provider Identification Number	145247
Address	1201 Hawthorn Road, Salem, Illinois, 62881
Investigation Completed	August 25, 2023
Deficiency Citations Issued	F600, F609, F610

Case 6 – Fear of Retaliation After Sexual Abuse

The nursing home failed to ensure that two residents (R1 and R2) remain free from abuse. This failure resulted in R1 and R2 being sexually abused by V3 (CNA).

R1 had **"intact cognition"** (BIMS score of 15 out of 15). His diagnoses included: Acute and chronic respiratory failure with hypoxia, anxiety disorder, and dysphagia following cerebral infarction. R1's Care Plan instructed staff to "Apply moisture barrier cream after each incontinence episode."

R1 said that a Black guy (later identified as **CNA V3) was putting lotion** on his buttocks and as he was putting it on, he was also putting it **in his private parts** (R1 showed with a hand gesture, moving his hands up and down as V3 put the lotion) **and playing with it**. R1 stated he told V3 to stop and get out of his room. R1 stated he was very upset and angry when V3 was doing this to him because **he felt violated.** He said that he has been in the nursing home for one year and no CNA has ever done this to him before. He stated that he was safe at the nursing home as long as V3 does not take care of him.

Three days after his report, R1's wife came to visit him. At some point, she came out of his bedroom screaming to LPN (V9) saying R1 was sexually abused and no one had told her about it. She said that **a male CNA had (Jagged) rubbed R1's penis** back and forth, **masturbating R1**. V9 informed the Administrator about it. R1's family called the police.

R2 was **"cognitively intact"** (BIMS score of 15 out of 15). His diagnoses included, among others, acute respiratory failure with hypoxia, and [de-identified serious medical condition].

R2 said V3 **"played with him"** three days ago while providing ADL care. R2 said the CNAs usually put skin breakdown prevention cream on his buttocks; **no one has ever applied it to his penis, going up and down** (this was the first time it happened to him since he moved to the nursing home 2 years ago).

R2 was **fearful that the surveyor works for the nursing home** and stated he **doesn't want to talk much about it because V3 is a tall strong guy and he R2 is a sickly person who cannot defend himself** and **if V3 knows R2 told the surveyor about what happened, he (V3) might retaliate**.

R2 was tearing up and crying as he told this to the surveyor. R2 said he **does not want V3 to come back to this unit and work there because R2 was scared of him.** R2 said he wants to file a complaint with the police so he can be safe here if V3 comes back to work at the nursing home. R2 said he was safe at the nursing home as long as V3 does not take care of him.

R2 told CNA (V6) about the sexual abuse incident and V6 reported it to LPN (V9). R2 also told Staffing Coordinator (V4) he didn't want the male CNA to provide care to him due to very rough care. V4 reported it to the Administrator. V3 was escorted out of the building pending investigations.

Name of Nursing Home	Warren Barr South Loop
Provider Identification Number	145632
Address	1725 South Wabash, Chicago, Illinois, 60616
Investigation Completed	January 31, 2024
Deficiency Citations Issued	F600

Case 7 – "Terrified" of Involuntary Discharge After Expressing Care Concerns

The nursing home failed to ensure: a. Residents were free from mental abuse per the nursing home's policy. **This failure resulted in R1 and R7** becoming **fearful of being involuntary discharged** by the Administrator (V1). b. Resident abuse allegations against V1 were reported to the Department of Public Health and investigated per nursing home policy. R7 was **"cognitively intact"** (based on MDS assessment) and her diagnoses included chronic kidney disease, chronic obstructive pulmonary disease, oxygen dependence, and breast cancer. R7 received radiation for her breast cancer and returned to the nursing home in a bad mood. She said that she never yells at staff, but she became aggravated when a CNA would not provide her ice chips due to her fluid restriction. R7 stated she yelled at the CNA and later apologized to the CNA.

R7 stated the next day V1 came into her room and told her:

> **"Unless I change my attitude, I will have to leave."** She said that V1 was nasty and threatening in the way he said it. R7 stated, **"He meant business' and "I was scared**." R7 stated she became angry, felt very unwanted, **felt like V1 wanted to throw her out of the facility…Just throw me out!"** R7 stated **she was unable to fall asleep for a few nights…**kept thinking about the incident. R7 stated that **she was concerned that if V1 kicked her out of the nursing home, she was not sure where she would go.** V1 denied making those discharge threats.

R1 was **"cognitively intact"** (based on MDS assessment) and was totally dependent on staff for bathing, required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. R1 stated V1 did not like that **R1 complained about the quality of the nursing care** at the nursing home and R1 felt that V1's objective was to pronounce R1 mentally incompetent so V1 could control R1. R1 stated everything V1 has done to R1 was about complete control – including repetitive requesting R1 submit to a psychological evaluation, denying hospice services, and proceeding with an **involuntary discharge because R1 complained about the care** R1 was receiving.

R1 stated he was being discharged because he was told the nursing home did not have the ability to assist R1 with his ongoing deteriorating condition. R1 stated he asked V1 if he could hire a private caregiver to help him at the nursing home, which V1 did not allow. R1 stated the involuntary discharge came out of the blue and **R1 had concerns regarding retaliation from V1.** R1 stated there were several excellent staff, but R1 had concerns about other caregivers who left him in pain and refused to turn him when requested. R1 also had concerns about call light response time (especially on second shift) and wanting two baths a week (not one).

R1 stated: "**V1 basically just wants to get rid of me."** R1's daughter said, "**If you heard some of the bullying that comes out of his mouth to dad and me, you wouldn't believe he was in this industry."** She said her dad "is **terrified regarding retaliation**."

Name of Nursing Home	Elmhurst Extended Care Center
Provider Identification Number	145111
Address	200 East Lake Street, Elmhurst, Illinois, 60126
Investigation Completed	September 26, 2022
Deficiency Citations Issued	F600, F610

Case 8 – "*I fear for my life if she loses her job,*" referring to abusive CNA

The nursing home failed to: a. Prevent a resident (R1) from being physically, mentally, and verbally abused by a staff member. **This failure resulted in R1 feeling fearful**, feeling unsafe, and R1 stating R1 felt like garbage. b. Implement abuse policies and procedures after an allegation of abuse was made for R1. c. Report an abuse allegation to the State Agency for R1. d. Do a thorough abuse investigation on two occasions for R1.

R1 said:

> "It was horrible. My roommate saw it and CNA (V6) saw it. The CNA reported it. From the first day I got here V5 had been bothering me. V5 came up to me the first day and said, "I hear you don't like CNAs." V5 said she comes into my room to see R4 my roommate. But R4 says she doesn't really know her." One day, V5 "entered my room to talk to R4. Before she got to R4, **I told her we did not want her in our room**. V5 entered our room again later and I began screaming at her to get out (CNA V6 who witnessed it said V5 told R1 to **"Shut the f**k up"**). V5 said she could be in here if she wanted and she could do whatever she wanted. I tried to block her with my body from entering the room. She entered the room four or five times despite me yelling and telling her to get out. V5 then **called me a "Fat a**" and "B**ch" and pushed my walker into me almost knocking me over**. CNA (V6) confirmed that V5 said those things to R1 and added that when she heard it, "My jaw dropped." **V6 said**, **"I observed V5 physically and verbally abuse R1."** Referring to V5 all of a sudden being exceptionally nice to her ("We didn't have a special relationship"), R4 said, "I could see this thing escalating and it scares me."
>
> "**This incident made me feel like sh**, garbage. I cried. I was so upset. I felt like less than what I am.** I told the Administrator (V1) about the incident the next day. They wouldn't fire her. They offered to move me to another room or facility. This was disgusting to tell you the truth. **I don't feel safe when V5 is around**. She intentionally seeks me out and makes sure I see her. V5 comes in my room and down our hall when she isn't even assigned here."

R4 confirmed that V5 pushed the walker into R1 and "she almost fell. I saw it happen and CNA V6 was in the room also. V5 called R1"Fat a**." I didn't report it to anyone, but I know R1 and V6 did." LPN (V7) said, "**V5 going into R1's room was like throwing gasoline onto a fire."** V7 added, "V5 always comes up with excuses for her behavior" and "I can't believe she's still employed here." R1 said it started in the dining room. V5 is rude and ignorant to me all the time. V5 came up to me in front of my tablemates and said, "I hear you were telling people I was rude to you." And I said, "Well, you were…. She finally left after I raised my voice. It all just escalated from there. **I fear for my life if she loses her job. Like a postal worker, she'd come back and shoot me.** I don't want to get anyone hurt. I'd try to fight her. I'd lose but I won't be silent. **She scares me, and I can't do anything about it."**

Name of Nursing Home	Franklin Grove Living and Rehab
Provider Identification Number	145200
Address	502 North State Street, Franklin Grove, Illinois, 61031
Investigation Completed	September 21, 2022
Deficiency Citations Issued	F600, F607, F609, F610

Case 9 – Fear of Retaliation After Theft of Credit Cards While in Hospital

The nursing home failed to protect R1 from misappropriation of property by staff resulting in a resident experiencing financial and identity theft and financial hardship leading to psychosocial harm.

The Administrator stated that R1's belongings were secure in her bedroom in her stand next to her bed and clothes in the closet when she was transferred to the hospital on a Wednesday. On Saturday morning the R1's belongings were to be picked up by her family, so the Housing Supervisor (V10) asked Housekeeper (V8) to pack up R1's bedroom on the same day to prepare for the pickup.

The Administrator stated that R1 notified LPN13 that on Saturday evening **her debit card was used by someone at the nursing home** (after noticing **unauthorized charges on her account**). She added that LPN13 reported that R1 called again and reported that her daughter picked up her purse and used a debit card at a restaurant. This false statement made R1 very angry and upset. She said that **she is the victim of theft,** and the nursing home tried to make it appear to the police that she was not in her right mind; making up an imaginary daughter to cover up what had been done.

The next day LPN13 informed the Administrator that the police were at the nursing home and that R1 reported to police that her card was stolen and that she did not have a daughter. Video footage from local businesses showed Dietary Aide/Maintenance Staff (V9) using the R1's credit cards.

The Administrator stated she believes when Housekeeper (V8) packed up R1's bedroom, she found the R1's purse and gave it to Dietary Aide/Maintenance Staff (V9). Housekeeper (V8) and Dietary Aide/Maintenance Staff (V9) were related. V9 is V8's son. Police investigation revealed V8 did remove R1's purse from her bedroom and V9 obtained the cards and used them.

R1 was **reluctant to take the surveyor's call for fear of retaliation** from the nursing home and because the nursing home had already made a false report to police on her behalf, and she wasn't sure if the surveyor's attempt to reach her was another attempt by the nursing home to trick her.

R1 stated she was **going through hell as a result of having her purse stolen** and that she can't afford to replace these stolen items: expensive earbuds, prescription medication, identification cards, and every credit card she had. She added that her Church had to provide her with financial assistance because she wasn't able to acquire the items she needed. The resident stated that while all this is going on, she is in the middle of trying to learn to walk again. She feels mistreated by the nursing home and **because she was in fear for her safety, she refused to return to the nursing home.**

The employment of Housekeeper (V8) and Dietary Aide/Maintenance Staff (V9) was terminated. Dietary Aide/Maintenance Staff (V9) was arrested and charged with felony identity theft.

Name of Nursing Home	Generations at Applewood
Provider Identification Number	145781
Address	21020 Kostner Avenue, Matteson, Illinois, 60443
Investigation Completed	January 5, 2022
Deficiency Citations Issued	F602

Case 10 – "Extremely fearful" of Retaliation if Staff Knew Verbal Abuse Has Been Reported

The nursing home failed to: a. Ensure call lights were answered in a timely manner and that all residents were treated in a dignified manner for eight residents (R1, R2, R3, R4, R5, R8, R9, R10); b. Ensure residents were free from **verbal abuse** for residents **R1** and R9; c. Ensure an allegation of verbal abuse was immediately reported to the Administrator/Abuse Coordinator and State Agency for R1; and d. Act upon the facility Abuse Protocol to protect residents from potential verbal abuse by an alleged perpetrator and thoroughly investigate an allegation of verbal abuse.

This summary below only addresses those violations specific to residents' fear of retaliation.

The Ombudsman (V9) stated that several residents have recently reported to her that staff are using abusive language towards them and/or other residents. V9 stated there has been a recent incident of administrative staff being informed of a staff member being verbally abusive towards a resident, and the Administration did nothing about the incident. V9 stated that **the resident** involved **is extremely fearful of staff retaliation if they know the verbal abuse has been reported.**

R1 had **no cognitive impairment** (BIMS score of 15 out of 15) and required extensive assistance of two staff members for bed mobility and toileting.

A review of Grievance/Complaint Report indicated that R1 said that CNA (V3) told her to "shut her mouth and learn how to talk to people." R1 stated that CNA (V3) always talks to her like that. R1 stated that she is **fearful of this 3rd shift staff member**, **and feels she cannot express her wants and needs, due to how 3rd shift staff responds back to her**. R1 added that the statements the 3rd shift staff member makes towards her **make her feel** uncomfortable and **scared.**

In a separate interview, the Activity Director (V5) stated that R1 told her that the incident in which CNA (V3) told the resident to shut her mouth took place when CNA (V3) was repositioning the resident in bed and the resident was worried that she might fall off the bed.

Social Service Director (V6) stated she interviewed R1 regarding the allegation of verbal abuse she has made the previous day. V6 stated that R1 was **very anxious even telling her what happened, because she isn't the type of person that wants anyone to be in trouble**. V6 stated that R1 did ask that CNA (V3) not take care of her anymore, because she was **scared of CNA (V3).** V6 concluded that R1 had never made allegations of abuse by staff before or asked that specific staff not provide her care. V6 stated that R1 did seem **truly fearful of CNA (V3)** after the incident occurred.

Name of Nursing Home	River Crossing of Peoria / Alternative name: University Rehab at Northmoor
Provider Identification Number	145647
Address	1500 West Northmoor Road, Peoria, Illinois, 61614
Investigation Completed	March 4, 2021
Deficiency Citations Issued	F550, F602, F607, F609, F610

Case 11

"What am I supposed to do when you leave? I still must live here. I don't want to talk anymore"

The nursing home failed to follow their abuse policy and procedures to prevent residents from being verbally abused, sexually abused, and **intimidated by staff members** (V31, V20, V33). This applies to seven sampled residents and has the potential to affect all 61 residents in the nursing home.

During a Survey Resident Council Meeting, residents voiced concerns regarding direct care staff. They initially spoke freely during the group interview, but then **two residents wished to remain anonymous because they were afraid of retaliation**, as the subjects of the concerns being voiced were related (Nurse V33 is the mother of CNAs V20 and V31) and were known to work different shifts.

Anonymous R2 said:

> "CNA (V31) is a relative of CNA V20 and Nurse V33 and never gives help when I need it. One time, V31 handed me a diaper, told me they had showers to do and walked out of the room. I felt humiliated because I am not able to change or clean myself up, and I felt that is what she (V31) expected me to do."

R54 stated, "**I witnessed CNA V20 tell my roommate (R49)** to **"Shut the f*** up."** We told the Administrator and the Charge Nurse, and they didn't do anything about it. And we must see him (CNA V20) every day. He keeps working in our room. His mother (V33) is a Nurse that works here."

R49 had a **high level of cognitive functioning** (BIMS score of 14 out of 15). During an interview, the resident stated that a couple of weeks ago he had a verbal altercation with CNA V20. He said that he reported it to "the lady who runs this establishment." She said she'll talk to him (CNA V20) and his mother (Nurse V33). The resident became increasingly irritated with the interview, sat up visibly angry and said, **"Now that you are asking me and bringing this up again, what am I supposed to do when you leave? I still must live here. I don't want to talk anymore."** The surveyor agreed to come back to speak with the resident later in the afternoon. When the surveyor returned, she/he asked the resident, "How do you feel about your interaction with CNA V20?" The resident stated, "I feel upset." The resident indicated that he **feels scared and at risk of retaliation.**

The surveyor confirmed that one of the actions the nursing home took to remove the Immediate Jeopardy determination was that it terminated the employment of CNA V31, CNA V20, and Nurse V33.

The nursing home stated, "Resident Council will be held to ensure residents understand the reporting process, have access to facility's hotline and the Administrator. Residents will be notified that **retaliation by staff will not be tolerated**, and staff will be disciplined up to and including termination."

Name of Nursing Home	Aperion Care Hillside
Provider Identification Number	145996
Address	323 Oakridge Ave. Hillside, Illinois, 60162
Investigation Completed	April 14, 2022
Deficiency Citations Issued	F600

Case 12 – "*She was trying to punish everybody. I felt it was unfair*" / "*I got scared the whole day*"

The nursing home failed to protect residents' rights to be free from mental abuse as evidenced by staff witnessed speaking inappropriately to residents. **This failure resulted in the residents expressing** feelings of **fear** and sadness. This failure applied to four residents (R3, R4, R5, & R6).

The Assistant Director of Nursing (ADON) stated she/he was notified that yesterday the Assistant Psychiatric Rehabilitation Services Coordinator (APRSC) V13 was called to the care unit to find out why the residents were having so many behaviors that day and to see what was going on. The ADON stated that APRSC V13 "became verbally aggressive towards the residents."

The Central Supply Manager (V11) witnessed APRSC V13 "screaming at the top of her lungs!" S/he heard her saying, **"I will shut down the whole 7th floor smoking down and no one will smoke. I've done it before, and I will do it again."** V11 added, "She was talking to the residents like they were her children." V11 stated, "I went to my administrators V6 and V14 and told them what happened."

V13 was sent home immediately. The managers interviewed the residents about the incident and found that four residents were affected by it.

R5 said that APRSC V13 was "hostile and volatile" when she addressed everyone, adding, **"I got scared because she said she would shut down everything on the unit. I was scared that I was going to lose my privileges of socializing on the unit and not be able to smoke or be able to use my pass to see my family."**

R4 stated:

> APRSC V13 "came up to the floor saying **if the floor gets out of hand again, we would not be able to smoke**. She was yelling and screaming. **I think V13 would have retaliated**. It made me feel sad when she was raising her voice at me**. I thought she would punish us all because she said she would**. Personally, **I got scared the whole day."** The resident added, "Some of us look up to the staff and I think we have the right to get treated with respect and dignity. We feel let down because this is a person who we go to when we need something."

R6 shared her/his thoughts about APRSC V13's yelling and threats, "I felt kind of bad because she was going to shut down the smoking. **I think she should have done something about the people who were doing it. She was trying to punish everybody. I felt it was unfair."**

R3 shared his/her thoughts about APRSC V13's yelling at the residents, **"I just ignored her because based on something I say, the staff will stick me with needles and send me out to the hospital."**

APRSC V13 was terminated for violating the abuse policy and for verbal abuse.

Name of Nursing Home	City View Multicare Center
Provider Identification Number	145850
Address	5825 West Cermak Road, Cicero, Illinois, 60804
Investigation Completed	July 1, 2021
Deficiency Citations Issued	F600

Case 13 – Residents Afraid of Abusive Nurse / Threat of Physically Abusive Retaliation / *"I was worried that she would try to kill me by overmedicating me" / "I feared for my life"*

The nursing home failed to prevent mental, verbal, and physical abuse from a Registered Nurse (V4) to eight residents (R1, R2, R4, R5, R6, R7, R8, R9). **These failures resulted in the eight residents having** increased on-going feeling of anxiety, crying, and **fearfulness**, R4 and R5 sustaining physical abuse, and R7 sustaining bullying/disparaging comments regarding her disease.

The nursing home also failed to: a. Immediately remove the alleged perpetrator RN (V4) after allegations of verbal, physical, and mental abuse were made; b. Thoroughly investigate these allegations, and c. Report these allegations to the state agency for the eight residents. **These failures resulted in RN (V4) remaining in the nursing home and working directly with the eight residents, which resulted in these residents suffering continual** abuse, **fear, retaliation,** and bullying from RN (V4). The Administrator and Director of Nursing (DON) failed to immediately act upon and follow-up on numerous physical, verbal, and mental abuse allegations.

The RN (V4) was described by residents as "very disrespectful," "mean," "very hateful," and "bullying." R4 had "**moderately impaired cognition"** (based on MDS assessment). Service attendant (V5) stated, "Around 6:30 PM, **R4 was masturbating** in the little room connected to the nursing area. **RN (V4)** went up to R4, **grabbed his penis, and screamed, "If you don't stop that, I am going to rip that thing off." R4 screamed** because the RN (V4) grabbed it so hard.

R5 who is "**cognitively intact"** reported that RN (V4) was openly mocking resident 7 at mealtime. R7 has **dementia** and a repetitive verbal tick where she frequently says, "the-the-the." R5 witnessed RN (V4) mock and repeat this tick to the resident and to other staff**. R5 feels that other residents and staff are fearful of RN (V4) and concerned about retribution if they were to report her**.
During an interview, R5, who at times stood up to RN's (V4) abusive behavior toward other residents, stated:

> "**The CNAs would tell me to watch my back**. **I was worried every night I lived there that RN (V4) would do something bad to me. I asked that RN (V4) not take care of me, but she still continued to take care of me. I was worried that she would try to kill me by overmedicating me."**

R6 was "**cognitively intact**." The resident stated that one day RN (V4) "jerked me out of my chair, stomped on my feet, and punched me in the stomach. I told RN (V4) my feet were bleeding and RN (V4) said,' Good.'" The RN (V4) "then swung me around and threw me on my bed…**I feared for my life."**
R8: **"I am not going to tell you anything about who has been mean to me. If I do not tell, then I do not get in trouble. If I told you what she has done to me, she would just make my life worse."**

Name of Nursing Home	Sunset Home
Provider Identification Number	145800
Address	418 Washington Street, Quincy, Illinois, 62301
Investigation Completed	April 28 2022
Deficiency Citations Issued	F600, F610, F835

Case 14 – "Reflexive" Retaliation – Throwing a Metal Tray at a Resident with Dementia

The nursing home failed to prevent a staff to resident incident of abuse. This affected R1. This failure resulted in **R1 diagnosed with dementia** being involved in a **verbal altercation with staff** which **escalated to V3 throwing a metal tray at R1. Using the reasonable person concept would cause R1 to be fearful of V3's impulsive and abusive behavior**.

R1 has a Care Plan for Cognition/Memory Impairment: R1 is an adult with **impaired cognitive function / dementia** and **poor memory recall** may impact level of alertness, decision making tasks and responsibilities. Interventions included, among others, "Please stop and return to me at a later time if I become agitated." Abuse/Neglect Care Plan included, among others, "Take steps to calm me and help me feel safe. Provide reassurance to me and remind me that I am in a safe and secure environment with dedicated and caring persons."

Police report reads in part:

> "The video footage revealed V3 and R1 in what looks like a verbal altercation that turned **V3 grabbing the tray of food** that was on the table **and throwing it at R1**. V3 explained he was in a verbal altercation with R1 in which **R1 grabbed a cup and threw it at V3 so in response, V3 took the tray of food and pushed it toward R1**. V3 advised he did not throw the food and tray directly at R1. V3 was issued a Municipal Ordinance for Battery and escorted off the facility."

Note on "Reflexive" Retaliation added to this summary (not included in the investigation report):

CMS states:

> "When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility's responsibility to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. All staff are expected to be in control of their own behavior, to behave professionally, and should appropriately understand how to work with the nursing home population."

CMS adds, 'A facility cannot disown the acts of staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment.'

The federal agency adds, '**CMS does not consider striking a combative resident an appropriate response in any situation. It is also not acceptable for an employee to claim his/her action was 'reflexive' or a 'knee-jerk reaction' and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited**' (CMS State Operations Manual, October 21, 2022).

Name of Nursing Home	Tri-State Village Nrsg & Rhb
Provider Identification Number	145879
Address	2500 East 175th Street, Illinois, 60438
Investigation Completed	October 12, 2023
Deficiency Citations Issued	F600

Case 15 – CNA "*was the epitome of fear of someone who is blind without legs*"

The nursing home failed to prevent abuse for R1.

R1 is **legally blind** and "**alert and oriented**" (BIMS score of 15 out of 15). The resident's diagnoses included, among others, chronic obstructive pulmonary disease, type 2 diabetes mellitus, acquired absence of right leg above the knee, and acute angle-closure Glaucoma (left eye).

R1 required extensive assistance with transfers, bed mobility, and toileting, and is dependent for locomotion on and off the unit. The MDS further states: R1 is always incontinent of bowel and bladder.

R1 stated CNA (V15) had told him she did not want to take care of him and **threw a package of pop tarts at him when he asked for a snack**. R1 stated he **felt fearful towards V15 and felt vulnerable because he is blind**. He said he told his son about the incident and his son told Administrator (V1).

The Director of Nursing (V2) stated, "R1 told us V15 had come into his room and told him if she put him to bed, she would not be able to get him back up, but he wanted to be up so he could go out and smoke." V2 stated, "R1 reported V15 told him if he went back to the bathroom in his pants, she would not be able to change him. R1 told V1 and V2 that he had **asked V15 to get him a pop tart** out of his cabinet where he keeps a bag of snacks, **and she threw the entire paper bag,** including pop tarts and a box of cereal, **at his chest, and it startled him because he is blind and did not see it coming**."

V2 stated:

> "I guess he had a bowel movement and V15 did not change him, and he did not get changed until the next shift." V2 stated R1 told them "**V15 was the epitome of fear of someone who is blind without legs."** She stated they did not know the exact date when the abuse occurred, but they thought it was the weekend before R1's son reported it. V2 stated she immediately suspended V15 pending the investigation and asked V15 to come into V1's office and give a statement. V2 stated at first V15 refused to come in, but then did come in the next day and the only thing she said was, "I didn't do that." V2 stated she terminated V15 that day for abuse.

A note in a Serious Injury Incident Report stated that the nursing home investigated the abuse allegation and concluded, "**The abuse is substantiated."**

Name of Nursing Home	Helia Southbelt Healthcare
Provider Identification Number	145241
Address	101 South Belt West, Belleville, Illinois, 62220
Investigation Completed	December 29, 2022
Deficiency Citations Issued	F600

Case 16 – Fearful Abusive Agency Aide "*will come walking through the door*"

The nursing home failed to ensure: a. R1 was free from abuse. This failure resulted in R1 being held down and **threatened by a CNA**. R1 remained tearful at times, and **fearful the staff member would return.** b. An allegation of abuse was immediately reported to the Administrator for R1. R1 was "**cognitively intact**" and had a diagnosis of heart failure. The resident had difficulty walking and required one person assist for toilet use, dressing, transfers, and personal hygiene.

A nursing progress documented:

> R1 was **tearful and anxious** and **wanted to know where she was**. When questions about it, he said he referred to CNA (V7) "the red head from last night [who] got in his face and **yelled at him that she was "the f***ing boss now"** and he (R1) needed to answer to her." R1 told the nurse he was held down by his arms and could not move. In another nursing note, R1 said that while **the aide held him down, she told him he was going to do what she told him**. R1 said no one has ever spoken to him that way and **it scared the hell out of him**. R1 said **sometimes he gets fearful the aide will come walking through the door.** R1 appeared visibly upset when recalling the incident.

CNA (V9) said she was working with CNA (V7) between 4am and 5am. V9 said V7 came out of R1's room and was upset R1 had no incontinence briefs in his room. V9 said V7 found briefs and returned to R1's room and was in the room for a long time. She reported V7 said **R1 was bickering with her about not having the briefs available in the room** and **V7 was getting upset with R1.** V9 said V7 told her she had **grabbed R1 by his shirt** and was telling him not to talk to her like that, and **when she put him into bed, she pinned R1 down by his arms.** V9 said V7 reported to her that **as she was pinning R1's arms down, V7 told R1 there was no camera in the room and nothing stopping her from hurting him**. V9 said V7 was showing her how she then **waived her fist in R1's face while threatening him.**

R1 reported the incident to CNA (V10) who said R1 was "**very shook up**" and that he didn't want that CNA back in his room. V10 immediately reported the incident to Human Resource Manager (V8).

The Director of Nursing (DON) said she was notified of the allegation of abuse and began her investigation. The DON said **V7 was an agency aide** and immediately dismissed from all further shifts. The DON said during her investigation she interviewed staff and concluded the incident had occurred.

The DON said V9 should have reported to the Administrator immediately when V7 told her of the incident. The DON said since the incident was not reported, V7 was allowed to finish her shift after the abuse occurred with R1.

Nursing home Incident Report stated, "The facility is finding this **allegation of abuse substantiated."**

Name of Nursing Home	Manor Court of Rochelle
Provider Identification Number	146193
Address	2203 Flagg Road, Rochelle, Illinois, 61068
Investigation Completed	December 17, 2021
Deficiency Citations Issued	F600, F609

Case 17 – Fear of Having Her Food Poisoned

The nursing home failed to treat and interact with R1 in a respectful and dignified matter when a staff member (V8) began using R1's personal space to store her personal items and alleged to withdraw social communication with the resident. R1 had "**moderately intact cognition**" (BIMS score of 12 out of 15) and lived with the following diagnoses: Cerebral palsy and major depressive disorder.

R1 told a surveyor there was an agreement with staff that they (CNAs V8 and V9) could keep personal belongings in her (R1's) closet. One day V8's snacks were missing from R1's closet. V9 texted R1 that **V8 accused her (R1) of stealing the snacks.** V8 subsequently started acting weird (would not say good morning, would storm away from the door and roll her eyes). R1 reported V8's behavior to the Administrator (V1) and requested that V8 no longer be assigned to her. R1 stated she felt emotionally hurt because, "**We developed a friendly relationship and to see it go from friends to almost enemies overnight**, I was like this is too stupid for me." R1 added that V8 was suspended briefly but then allowed to work on R1's floor as long as V8 didn't have direct contact with R1. However, R1 stated that V8 would get the new CNAs on her side and they treat me like they don't see me. **R1's family believes V8 is retaliating against R1 for reporting her behavior to V1. R1** denied being scared of V9 but she **does not feel safe with V8 working on the floor due to fear of poisoning her (R1's) food.**

V8 stated:

> "I put my work bag in R1's closet and there was some stuff missing out of it. It was some food items. Maybe a couple of months ago… I got here at 7am and when I got home, I noticed the food items were missing. I didn't report it to anybody. I didn't tell any coworkers about the incident. R1 brought it to management. They called me at home. R1 said I took some of her stuff. I don't remember word for word. I was on suspension because R1 accused me of doing something. They called and told me to come back to work, the investigation was over. R1 is on one side of the facility. When they need me on this floor, I only work on another area. I am not allowed on R1's side of the facility. Other staff will get my linen and do my showers for me since I may have to walk past R1's room…" V9 stated she used to store her bag with soap and body wash in R1's room "because our locker room is in the basement" and she used these items to clean R1. She said, "R1 was aware of it. I never stored personal belongings. Just stuff for R1. V8 stored her personal belongings like a jacket or purse. V8 went to get her things, once she got home, V8 noticed her bag was open and wasn't sure what was missing. V8 didn't accuse anyone. Just stopped putting V8's things in R1's room.' V9 added, "When I was R1's CNA, she would ask me why V8 was not coming around, why she is not bringing her stuff in there. I told R1 that no one said anything about who took stuff from V8's bag. Just that someone took it."

Name of Nursing Home	Parkshore Estates Nursing & Rehab
Provider Identification Number	145938
Address	6125 South Kenwood, Chicago, Illinois, 60637
Investigation Completed	June 30, 2022
Deficiency Citations Issued	F557

Case 18 – Pouring Ice Water on Head in Impulse Reaction ("Reflexive" Retaliation)

The nursing home **failed to prevent staff from retaliating against R12.** The failure resulted in V9 **pouring a cup of ice water over resident 12's head.**

The nursing home also failed to follow their abuse policy by not immediately reporting an allegation of abuse to the Administrator / Abuse Coordinator for R12.

It was reported to the Administrator that R12 threw a cup of water on V9 and V9 threw a cup of water on R12. Social Worker (V10) said she heard a shout from V9 and saw V9 get up and then heard V9 say, "How do you like it" or "How does it feel."

The final abuse investigation documented that V9 admitted to **pouring water/ice on R12 in an impulse reaction** towards resident 12.

An interview with V9 documented that Social Worker (V10) explained to V9 that it was abuse.

V9 acknowledged that her action of throwing a cup of water on the resident was abuse. V9 was remorseful and understood that her action was unprofessional.

The Director of Nursing stated, "**Retaliation is abuse**. The incident with V9 and R12 was abuse."

Due to the findings, V9 was relieved from her duties.

Social Worker (V10) is no longer working at the nursing home due to failure to immediately report an incident to the Abuse Coordinator.

The incident took place on a Sunday afternoon while the documents under Preliminary 24-hour Abuse Investigation Report indicated that the abuse allegation of the ice water incident was reported to the Administrator only on the following day (Monday) at approximately 9:50am.

The nursing home's Abuse Reporting and Prevention Policy stated, "Employees are required to report any incident, allegation or suspicion of potential abuse they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must report to the administrator immediately."

Name of Nursing Home	Aperion Care Chicago Heights
Provider Identification Number	145180
Address	490 West 16th Place, Chicago Heights, Illinois, 60411
Investigation Completed	February 28, 2020
Deficiency Citations Issued	F600, F609

Case 19 – "*Didn't tell anyone [about abuse] because I was afraid [CNA] was going to retaliate*"

The nursing home failed to: a. Follow their change in condition policy by notifying the attending physician and family of acute changes in condition to include skin changes of a port site and fall incident. This failure affected R19. b. Prevent an injury of unknown origin for 19. This failure resulted in R19 having multiple unexplained bruises under the left eye, left shoulder, and left forearm.

R19 was assessed to be "**alert and oriented** to person, place, and time." R19's family member (V67) stated (11/30/22), "R19 mouthed and pointed to CNA (V3) stating, "You hit me when V3 walked into the room on 11/24/22." R19 **accused V3 of hitting her in the face and pinching her.** The incident had to happen on 11/23 when I didn't visit. I spoke to V3. V3 stated, "I did not hit R19. I would never hit R19. I love R19. I would never hurt R19." Respiratory therapist (V16) told me, "R19 eyes looked swollen." I reported it to nurse (V4). Emergency Medical Technician (EMT) stated, "R19 had a black eye. I told R19 we couldn't prove the abuse but R19 keeps reporting the same thing. V3 is usually nice and takes care of R19 but something must have happened because R19 kept mouthing and writing V3 abused her.""

A report timestamped several hours later the same day (11/30/22) documented: Nurse practitioner (V77) stated she received a call from a female nurse that R19 had fallen out of bed and was not sure what happened on 11/25/22. V77 stated he gave orders to send R19 to the hospital. On 12/6/22 at 10:10am, R19's family member (V67) stated he was not notified of R19's fall until he was at the facility on 11/25/22. V67 said he did not receive any phone call on 11/24/22 to notify of any falls.

On 12/6/22 at 3pm, R19 stated:

> (CNA) V3 started **hitting (slapping) pinching me** two weeks after I arrived at the facility. **I didn't tell anyone because I was afraid V3 was going to retaliate.** V3 would get upset because I would push the call light. **V3 slapped my hands, both sides of my face and pinching my stomach**. R19 demonstrated where and how she was being hit and pinched by making a pinching motion over her stomach (lateral right side) and a slapping motion to the back of the hand and face on both cheeks with the front/palm-side of her hand. R19 was observed with two dissipating red circular spotted areas under eye bags (puffy areas under bilateral eyes on the lateral side). R19's lateral eye was observed with a dissipating blue crescent area similar to the shape of a crescent moon under the left eye bag/puffy area. R19 had a bruised/dissipating blue irregular shaped area on the left shoulder the size of a 5-cent coin, and a larger blue dissipating area that covered R19's bicep with two circular dissipating blue circular area underneath the bicep just above the antecubital space and a dark irregular square shape on the posterior arm located at the base of the triceps above R19's elbow.

Hospital paperwork (11/25/22) documented: Diagnosis: Suspect Elder Abuse. Skin: Bruising present. When asked if she (R19) **felt scared to return to her nursing home**, R19 nodded her head yes.

Name of Nursing Home	Elevate Care Country Club Hill
Provider Identification Number	145967
Address	18200 South Cicero Avenue, Country Club Hills, Illinois, 60478
Investigation Completed	December 20, 2022
Deficiency Citations Issued	F580, F600

Case 20 – Retaliatory Verbal and Physical Abuse After Requests to be Changed

"I was scared of her. I was scared she was going to hit me"

The nursing home failed to: a. Prevent the verbal and physical abuse of R1. **This failure resulted in** R1 having **mental anguish** during the abuse and continued mental anguish following the abuse. b. Follow its abuse prevention program by failing to prevent the verbal and physical abuse of R1. R1 was "**alert and oriented**" (as noted in the nursing home's Final Investigation Incident Report).

R1's witness statement documents:

> "About 12:45pm, I had my lights on and CNA (V5) came in and **I asked her to change me**. She said she was about to feed another resident and she would change me later. As **time passed** (later R1 reported to V6 that it was 45 minutes later) and I've seen her coming out of another resident's room and said, "V5, **I need to be changed**, (they) want me to do therapy." [later R1 told V6, "Therapy said they would work with her after she was cleaned up"]. **She got really close in my face and was yelling at me, "I've got all these people to take care of. I clean (expletive for feces) and I get no respect." She snatched my covers down and threw them to the floor** and **I said, "Please don't yell at me." She snatched my arm (forcefully) to turn me over and I said, "Wait (V5) my arm."** She said, "I've been on this hall and they (two other residents) are my witness that you are yelling at me to change you." **She changed me and didn't change my bed pan or gown. She said, "You will probably call your (family member) and Administrator (V1) but V1's in the hospital." I told her I am going to report her and she said, "If you don't, then the b****h across the hall would."** She (V5) gets mad sometimes, but she was bad this time and **I was scared."**

During an interview held a couple of weeks later, R1 stated with tears in her eyes that during the incident V5 got four inches from her face, "**screamed curse words at me including (f-word),** and was saying, "You aren't going to tell me what to do." R1 stated, "I asked her to calm down and even told her that she was my favorite because she was losing it and wouldn't quit yelling. I was trying to smooth her over. Then, she grabbed my arm and yanked me over and it hurt my arm. **I was scared of her. I was scared she was going to hit me.**" She added that the next morning CNA (V6) saw her crying and asked her what was wrong "so I reported the incident to V6." V6 said, "I reported it immediately." R1 told V6 that during the incident, V5 told R1, **"What are you going to do, call your (family) and report me?"**

The Director of Nursing (V2) stated when she interviewed R1, she "was pretty upset. **R1 was scared**." V2 added, "I didn't like that (R1) felt afraid so I told (V5) she could resign, or I would terminate her position." The nursing home's Final Investigation Incident Report documented: "V5 will be separated from the company for unprofessional behavior."

Name of Nursing Home	Accolade Healthcare of Savoy
Provider Identification Number	145439
Address	302 West Burwash, Savoy, Illinois, 61874
Investigation Completed	December 6, 2021
Deficiency Citations Issued	F600, F607

Case 21 – "*Scared to use the call light…so she just peed the bed*"

The nursing home failed to: a. Prevent an incident of mental abuse / neglect for R2. **This failure resulted in** R2 being **frightened, having nightmares, and afraid to use her call light.** b. Operationalize its abuse policy by not reporting an allegation of abuse immediately to the Administrator, allowing the perpetrator to have contact with residents after a potential incident of abuse, and delaying the investigation for 16 residents (including R2). c. Report allegations of abuse / neglect immediately to the Administrator for R2. d. Ensure alleged perpetrators of abuse do not have contact with residents after an alleged incident of abuse / neglect for 16 residents (including R2).

R2 was "**cognitively intact**" (MDS assessment) and required extensive assistance for toilet use.

A written statement written by CNA (V8) on behalf and in the presence of R2 and another staff member for a witness. The statement documents, "At 1:30am, night shift CNA (V3) came in to answer R2's light. **R2 needed the bedpan**. V3 told her she could only use it every two hours. R2 said she couldn't see the clock. V3 then said she would come in here and check the clock and if it wasn't time, R2 would have to wait. At 4:30am, V3 came in and told R2 she would be back at 5am to get her up. R2 said she didn't want to get up that early because that was too long to sit in the chair. This is not the first time V3 has come in and told her she was to wait to use the bedpan / bathroom. R2 is **afraid to use the [call] light because she doesn't want V3 to come in and start in on her.** R2 claims to have **peed the bed because she was afraid to use the light.** V3 also told her at her age she should be sleeping more instead of using the bathroom. V3 has told her several times since she'd been here, she has to hold it.

In a typed statement, R2 stated to LPN (V10), **"She [V3] wouldn't let me use the bedpan when I needed to."** She said, "I had to wait every two hours." R2 was very upset about this. V10 and V11 (LPN) assured R2 that V3 would not be back in her room and R2 stated, "Good, because I don't want her back in here." V10 informed the Administrator and the Director of Nursing (DON) about it.

In an additional statement, R2 said **V3 had told her to hold her pee because she "went pee too much** and she needed to wait every two hours." R2 said she couldn't wait…that she needed to go now.

CNA (V8) stated, "I watched V3's hall while she was on break that night. When I answered (R2's) call, she grabbed her chest and said, "I am so glad it's you!" She said that she needed to talk to me and told me that V3 was very rude to her. I told her I would definitely be reporting it. I took a witness with me and wrote word for word what R2 told me, and she signed it." Beyond other concerns about V3, "R2 told me she was **scared to turn on her call light.** R2 had a Urinary Tract Infection (UTI) at the time, so she certainly shouldn't have been hold[ing] it (urine). R2 told me **she was having nightmares and was scared to use her call light when V3 was working, so she just peed the bed**."

Name of Nursing Home	Taylorville Care Center
Provider Identification Number	145502
Address	600 South Houston, Taylorville, Illinois, 62568
Investigation Completed	September 29, 2021
Deficiency Citations Issued	F600, F607, F609, F610

Case 22 – Retaliation for Reminding Aide that She is to Receive a Shower That Day / Not asking for a shower because "*she could have hit me*" / "*I was afraid of her*. *It was trauma*"

The nursing home failed to prevent verbal / mental abuse of a resident. **The failure resulted in** psychosocial harm to R1 as exhibited by **crying, shaking, fear, feeling intimidated**, vulnerable and **threatened**, and experiencing **ongoing emotional anguish** after the abusive event. R1's "**cognition was intact**" (MDS assessment).

R1 stated: "CNA (V2) rudely flung her room door open, which slammed against her dresser drawers, and walked into her room." R1 stated V2 kept saying loudly, "It's gonna be a good day! Yes it is! And I am going to do what I have to do. It's gonna be a good day!" **R1 stated she reminded V2 that R1 was to receive a shower that day,** and V2 replied loudly, **"You're not getting a shower!** You are not scheduled today!" R1 stated she had not had a shower in five days. R1 stated she reminded V2 when V2 initially approached R1 to take a shower, R1 had a migraine headache and asked to postpone her shower until she felt better later. V2 yelled at R1 stating, "I am not going to give you a shower!" V2 told R1 because she declined earlier due to her migraine, R1 refused and V2 was not giving R1 a shower. R1 stated **V2 put her pointer finger within two feet of R1's face, shook it, and yelled, "You aren't getting an extra shower! I have things to do and you aren't getting a shower!"**

V2 yelled, "I am going to have a good day today and I'm not doing an extra shower!" R1 stated, "**It was abusive. I was shaking!**" R1 stated **she felt like she was being threatened, and was not going to continue to ask V2 for a shower because she was unsure what would happen next**. R1 stated, "**She could have hit me**." R1 then asked V2 to provide her with clothes from her closet. V2 opened R1's closet swiftly and stated, "Well, everything in here is dull!" R1 replied her sons were doing the best they could, and V2 responded, "Well, they aren't taking you home, so I guess I understand!" R1 began to cry during the interview and stated V2 tried to make R1 feel like her sons did not care about her. R1 stated she cried when V2 told her that. R1 stated **V2 kept telling R1 she had seniority at the facility,** and R1 **felt like V2 was trying to intimidate her not to get out of line.** R1 was very upset, shocked, and felt disgusting, angry, emotional, sad, and vulnerable. R1 stated **she shook the rest of the day** and began to cry again during the interview. R1 stated, "**I was afraid of her**. **It was trauma**, I will be honest. There are times I still cry because of what she said to me about my family not wanting me. It comes back to me."

R1 stated she was **unsure what to do next and did not know who she could trust**. R1 believes Nurse (V4) heard the yelling from the hallway and entered R1's room. R1 stated she told V4 everything that happened, and that she did not want V2 taking care of her again. R1 stated, "Someone in that line of work should not be working in any facility taking care of patients like that." Earlier, R1 told V4, "**I am afraid if she comes back**." V4 told R1 she reassigned CNA (V6) to R1's care and said V2 would no longer care for R1. R1 **asked** V6 **if V2 was still at the facility.**

Name of Nursing Home	Brookdale Plaza Lisle Snf
Provider Identification Number	146061
Address	1800 Robin Lane, Illinois, 60532
Investigation Completed	April 13, 2023
Deficiency Citations Issued	F600

Case 23 – Scared to report abuse but "*is now feeling better that she did*"

The nursing home failed to prevent employee-to-resident abuse for R2. **This failure resulted in** R2 experiencing physical and mental abuse, leaving **her to feel scared** and feeling unsafe in the facility. R2 was assessed as "**cognitively intact**" (BIMS score of 15 out of 15). Her diagnoses included Schizophrenia, Bipolar Disorder, and Generalized Anxiety Disorder, among others.

Progress Notes by LPN (V13) documented the following:

> Resident initially said to me that **she wanted to tell me something, but didn't want to if someone would get in trouble or if I would have to report it**. I said depending on what it is, I would have to report it. She said, "**Never mind**," but she eventually told me that one of the CNAs was being abusive to her. She said she was in her chair and the CNA wanted her to get up into bed, but demanded it, so she wasn't cooperating with her. The abuser tried to pull her up by her wrists and put a bruise and small cut on her left wrist. R2 also said the abuser yelled three times in her ear, "You're going to get up." **The resident was clearly scared to divulge the information to me.** After she told me about it, I immediately notified my Director of Nursing and HR manager, who notified the police. The police officer took V13 and R'2 statements. R2 said the incident happened around 10pm.

Police Report:

> R2 stated that the nurse came into the room and told her to get up, but she did not feel like getting up at that moment. She did not assist the aid or the nurse in moving her. R2 said that **this made the nurse angry, so she went to get the "bigger, bully, female CNA" to make R2 get up.** R2 said that **the CNA yelled into her ear three times that she was going to get her up** and **this scared her.** R2 then held her left arm out and I observed **a large bruise** on her left arm, above the wrist, and a small cut on her wrist. R2 said this happened when the CNA placed one arm on top of the other and attempted to pull her up. R2 then stated that it could have happened when the CNA grabbed her arm with her hand to pull her up. R2 stated that **she is scared due to the situation.** Follow-Up Investigation Report (three days after the police report) included: **Resident was scared to report the issue but is now feeling better than she did.** Resident claimed she stayed up late because she doesn't sleep much, and staff kept telling her she needed to go to bed. She told them she wasn't tired yet and she just keeps requiring less and less sleep the older she gets. Then, **they came into the room and forced her in bed**. The **resident appeared scared to tell what happened. The allegation of abuse was substantiated**. CNA (V15) claims that she put R2 to bed in the sit to stand (mechanical lift). V16 claims R2 was fighting by kicking, hitting, and biting but V15 still made her go to bed with the mechanical lift. **V15 was terminated for violating R2's right to choose** what time to go to bed.

Name of Nursing Home	Bria of Woodriver
Provider Identification Number	145655
Address	393 Edwardsville Road, Wood River, Illinois, 62095
Investigation Completed	June 17, 2024
Deficiency Citations Issued	F600

Case 24 – Sacred of Activity Aide and Fearful of Retaliation After Theft of Money

The nursing home failed to ensure that Resident 3 (R3) remained free from staff-to-resident theft. R3 was "**cognitively intact**" (based on MDS assessment).

R3 said he gave former activity aide (V4) his debit card and asked V4 to withdraw $900 from his bank account for R3. R3 stated that V4 returned with only $640 instead of the full $900.

The Social Services Director (V10) said R3 came to her office in late October and said V4 borrowed money from him and had not repaid him back. R3 explained that the incident occurred sometime in September, though he could not provide an exact date. R3 said he gave V4 his debit card, asked V4 to withdraw $900 from his account, V4 brought back $640. I informed the Administrator right away. Facility employees should not be taking a resident's bank card to withdraw money for a resident. **V4 should not have taken money from R3**. **That's financial abuse**. R3 told V10 that he was **scared of V4** and was **afraid of retaliation.**

CNA (V9) commented, "Staff should not take money from residents; you just don't do it, it's financial abuse." Similarly, Registered Nurse (V8) said, "Staff members should not take money from residents; it's a form of abuse." V4 was not available for an interview.

A note in the nursing home investigation stated that a couple of days after V4 brought R3 the $640, V4 asked to borrow $140. When R3 called to check his balance, it showed only $0.07. R3 said he had $900 on his card when he sent him. R3 stated he is **scared the male staff will retaliate.**

A text message between V4 and the Administrator provided additional context. In the message, V4 texted:

> "I went to the store for R3 two months ago to get money off his card at corner store. R3 agreed to give me $50 for going so I told him no instead of giving me for going no I'll [missing word] it back on such day which will be the 3rd and he agree and said OK."

A Corrective Action Form documented that V4 admitted to borrowing $50 from R3 two months prior. Following the investigation, V4's employment was terminated. The nursing home's **Abuse Prevention Program Policy** defines misappropriation of resident's property as : The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

Name of Nursing Home	Austin Oasis, The
Provider Identification Number	145834
Address	901 South Austin Blvd, Chicago, Illinois, 60644
Investigation Completed	November 17, 2023
Deficiency Citations Issued	F600

Case 25 – Retaliation for Borrowing Scissors for Art Project

The nursing home failed to:

a. Prevent mistreatment and verbal abuse of R2.

b. Immediately report an allegation of verbal abuse to the Abuse Coordinator for R2.

R2 was described as "**mildly cognitively impaired** "and [exhibited] both delusions and hallucinations." The resident's diagnoses included, among others, Schizoaffective Disorder, Major Depressive Disorder, and Generalized Anxiety Disorder.

An **Incident Investigation Signed Witness Statement** documented by CNA (V9) states :

"R2 went to the nurses' station to get her medications and was confronted by CNA (V8) for scissors that (V8) had loaned to R2. **V8 got mad and was screaming at R2 for the scissors and started throwing and dumping R2's bags for these scissors and made R2 cry**. V8 then followed R2 back to R2's bedroom screaming at R2 calling her names. R2 was screaming back at V8 and upon entering R2's bedroom, overheard V8 say, **"I'll go break all your things Motherfucker"** as R2 was telling V8 to get out of her bedroom. Once the screaming match was done, V8 proceeded to **slam R2's door** saying something and **calling R2 a "b**ch."** I had not reported [it] because I was not sure who to talk to and was scared of V8 because she becomes very confrontational."

CNA (V9) stated she did not immediately report the incident because RN (V11) was present during the altercation and assumed she would report. V9 reported the incident to another CNA and was advised that she has to report the incident to the Administrator (V1). Since V1 was not there at the time, she told Nurse (V10). V9 stated that V11 was also working the night she reported the incident to V10. V9 stated at that time V11 denied the incident occurred because V11 was worried she would be in trouble for not reporting the incident, but later V11 helped V9 write her witness statement.

RN (V11) stated that CNA (V8) dumped all of R2's belongings onto the floor at the nurses' station in front of the medication cart – and in front of R2 – looking for scissors that V8 stated she loaned to R2. V11 stated that **R2 did not like that V8 was going through her things or that she had dumped them on the floor**. V11 told V8 to put R2's belongings back in R2's bag and that it was inappropriate to dump them out. V11 stated V8 put R2's belongings into R2's bag. V11 stated she should have reported V8's behavior to the Administrator. V11 stated she then gave R2 her medications and left for lunch break.

In the investigation report, CNA (V8) claimed :

"**I admit to joking around with R2**. No harm was intended. R2 knows I was playing about her stuff. **Me and R2 always play around**." Several weeks later, V8 stated:"R2 had borrowed scissors from V8 for an art project and she forgot to get them back from R2." V8 added, "V9 is new and took it the wrong way. **I wasn't angry – just kidding."**

Name of Nursing Home	Allure of Galesburg
Provider Identification Number	145987
Address	1145 Frank Street, Galesburg, Illinois, 61401
Investigation Completed	November 30, 2023
Deficiency Citations Issued	F600, F609

Case 26 – Verbally Abusive Retaliation for Request to Stop Spraying Air Freshener in Bedroom

The nursing home failed to affirm the right of a resident to be free from verbal abuse. Staff member (V3) yelled at R1 during an argument that happened in the evening shift. R1 is "**cognitively intact**" (based on BIMS assessment). R2 (R1's roommate) was "cognitively intact."

An interview was conducted with the Administrator (V1). V1 stated that R1 reported an incident that happened on an evening shift. R1 reported to V1 that CNA (V3) **screamed at R1, was very rude, and very demeaning**. V1 stated that according to R1, the way V3 was talking to R1 was **very threatening**. V1 stated that R1 reported that V3 was arguing with R1 about an air freshener spray and started screaming a R1. V1 stated that during the investigation, V1 interviewed R2 who was R1's roommate. V1 stated that according to R2, R1 and V3 were screaming back and forth and were arguing like mother and son. V1 stated that according to R2, V3 told R1, "You're not my mother."

During an interview, R1 stated that around 7:30pm, **V3** had taken care of R2 **and started spraying air freshener towards R1's room**. R1 stated that she **(R1) told V3 to stop spraying**. R1 stated that **V3** stepped out towards the door, turned around and **started talking to R1 loudly and aggressively.** R1 stated V3 yelled at her (R1) saying, **'Don't you ever tell me how to do my job."** R1 stated that V3 was yelling and very rude to R1. R1 stated that V3 accused R1 of calling him (V3) the N word.

R1 stated that V3 started swearing and telling R1:

> "God Damit don't do that. No one calls me a n*****. You're crippled. You're handicap. My mother would not treat me this bad."

R1 denied calling V3 the N word. R1 stated that R1 **felt threatened**, unsafe, and **got scared because V3 is a big [Name]**. R1 stated, "**He's (V3) a [name] big guy yelling at a little person like me."**

During a phone interview with LPN (V12), V12 stated that R1 was re-assigned a different CNA and V3 was separated from R1.

Name of Nursing Home	Peterson Park Health Care Ctr
Provider Identification Number	145838
Address	6141 North Pulaski Road, Chicago, Illinois, 60646
Investigation Completed	November 14, 2022
Deficiency Citations Issued	F600

Case 27 – Retaliation After Resident Recorded His Own Intravenous Tubing

The nursing home failed to ensure a resident was free from physical abuse by a staff member. R1 is "**cognitively intact**" (based on MDS assessment).

R1 said that four days earlier at around 7:30am:

> RN (V3) "came into my room to give me IV (Intravenous) antibiotics. She put the IV tubing across my chest after she disconnected it from the bag of antibiotics and left it across my chest, still connected to my PICC (Peripherally Inserted Central Catheter) line. **I was worried germs were somehow going to go through the tubing into my PICC line** because she just left it on my chest. **I used my cell phone to take a video of the tubing attached to my PICC line** and bounced up on top of my chest. I was feeling very nervous that this would somehow do me harm. **V3 asked me if I am using the camera to record her**. **I explained I was recording the tubing across my bed and bounced up on my chest, not her. She left the room and then came back into the room ranting and raving**. I turned the camera towards her as she was screaming at me, "Don't video me! That is very rude! That is inappropriate!" **V3 then reached for the phone in my hand and tried to take the phone away from me. I told her I was recording the tubing coiled up on my chest and still connected to my PICC line, "but now I am recording you because you are scaring me, and I don't know what your intentions are toward me."** She physically touched me. She grabbed my hand.' R1 stated he "went and took a bus to the police and filed a report."

R1 showed the video described in his statement to this surveyor. The video on R1's telephone shows IV tubing draped across R1's chest, still connected to his PICC line as described by R1. The video also shows RN (V3) loudly speaking to R1, saying, "Don't video me! That is very rude! That is inappropriate!" **The video** continues to **show V3's hand coming towards R1's telephone, the screen obscured by a hand, and then the video stopped.** The nursing home's Preliminary Incident Investigation Report Form shows R1 reported to Psychiatric Rehab Services Director (V4) that RN (V3) "**smacked his cell phone off his hand."**

Two days later, V4 said R1 reported the abuse allegation to her 2 days earlier." "He is not satisfied with the level of care they are providing for him. **He likes to video tape our staff. He is doing this because he wants them to do the job correctly. He has the right to do so**, but he does it excessively."

On the same day, RN (V3) stated, among other descriptions and explanations pertaining to the incident: "I was blocking the phone because I didn't want him to record my face" and "I did not know it was part of his care plan to video. Nobody gave me that information. I would have been prepared for the video if I knew it was in his care plan. I thought no one could videotape me."

Name of Nursing Home	River View Rehab Center
Provider Identification Number	145308
Address	50 North Jane, Elgin, Illinois, 60123
Investigation Completed	May 23, 2024
Deficiency Citations Issued	F600

Case 28 – Fear of Retaliation If Residents Say Anything about CNA's Abusive Verbal Interactions

The nursing home failed to immediately begin an investigation into an allegation of verbal abuse of a staff member toward one resident (R2).

R2 stated:

> "Last Friday evening I had 3 run-ins with her (CNA E7). I visited with another resident's mom who I'm friends with. **I was helping her clean out the fridge in his room.** E7 came in and **started yelling at me to get out**, that I know better than to be in here. It was so embarrassing. Later on she said, 'It's time for your shower' and I told her I would take it later. Then she said, "No, I'm writing down that you refused." R2 said she always takes her showers without any problems. R2 continued, "Later, I wheeled my wheelchair into the main dining room to watch the TV news and she started yelling at me to get into a regular chair. Everything I do -- she always says I don't follow the rules. I've been here six years and have never had a problem with the rules. She makes them up because she wants to show she has authority. I got so upset after the last thing. I began to cry and left for my room yelling for her to leave me alone. **I stayed in my room all weekend because I was afraid she'd do it again**. This shouldn't be going on. It's like a power trip. I'm grown up just like her."

R2 said **she decided to stay in her room all weekend because she was afraid E7 would continue verbal abuse**. The resident said she normally would go out and visit others in the gazebo, or exercise with her walker out front. She went on to say that **she just wanted to be at peace again so it was best she not see E7**. R2 said that she has been a resident here for six years and never had a confrontation with anybody. R2 said she was still upset and decided to tell the administrator. R3, R4 and R5 described E7's abusive verbal interactions: R3 with "minimal cognitive deficit" (BIMS score of 13 stated E7 is "very controlling and condescending" and has witnessed her (E7) "yelling at R1 to hurry up and eat and not talk. Then they get into a shouting match."

R5 with "**no cognitive deficits"** (BIMS score of 15) stated about E7: "I don't know where she gets her ideas about the rules in this place. **E7 and another CNA rush us every meal when they work. I don't think it's fair they make us shove the food down our throat and tell us not to talk.** They say it's because they have to get the second cart in here. **R5 expressed concern staff will retaliate if residents say anything**.

R4 was "cognitively intact" (BIMS score of 15) and stated: "She (E7) is very domineering and treats grown residents like they're children. **I'm on the Resident Council and we get complaints about staff treatment all the time, a lot about her.** I'm at the point where I don't acknowledge her. She frustrates me that much. Staff know how she is. **They see her manage us like we're in the penal system** [also known as a correctional system]. **The minute you challenge her, she runs to whoever is in charge and makes up stuff and that starts a fire**. And they tend to believe her. It's best just to ignore her."

Name of Nursing Home	Aperion Care Wilmington
Provider Identification Number	145316
Address	555 West Kahler, Wilmington, Illinois, 60481
Investigation Completed	June 16, 2016

Deficiency Citations Issued	F225
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 29 – Fear of Retaliation if Reported Being Abused by CNA (per Family report)

The nursing home failed to prevent verbal and physical abuse from occurring. **This failure had a psycho-social impact**, as R1 experienced **fear of retaliation if she reported the abuse**. R1 diagnoses included, among others, **dementia**, major depressive disorder, heart failure, and morbid obesity. The MDS assessment shows R1 has "**moderate cognitive impairment**," requires extensive assistance with ADLs, and is occasionally incontinent of bowel and bladder.

The nursing home Incident Investigation Report shows: On June 19, 2017, at around 8:45 PM, family member of [R1] reported to the nurse that **CNA (E4)** assigned to [R1] **was rough putting [R1] to bed**, stated that R1's hand was forcefully pushed to hold on the side rail during transfer from wheelchair to bed. Nurse on duty immediately assessed the resident with no signs of any injuries, able to move extremities. E4 was immediately suspended until investigation was completed. The incident report showed **the abuse allegation was substantiated** and E4 was terminated.

Director of Nursing (E2) documentation dated June 20, 2017:

> Resident was asked if she had experienced any situation that made her feel uncomfortable and she replied: "Last night I was sitting up in my wheelchair when [E4] informed me that she had to place me in bed. **I didn't want to go to bed but with [E4] you have to do what she says because she is the boss.** You know [E4] has a lot of problems, and I don't want to make more trouble for her. So, I happen to be wearing a house coat and my legs were exposed and of course it makes it a little difficult to move when my skin is touching the pad to slide. **[E4] kept insisting that I slide so she got upset because I was not moving as fast as she wanted me to, so she grabbed me by my wrist and I felt pain travel up to my shoulders.** I have very bad arthritis and tend to experience pain because of this. **The pain was so bad that I screamed and began to cry because she was manhandling me."**

Upon assessment of [R1's] bilateral medial wrist there was a light bruise forming. R1 identified two additional incidents with E4. One of them is described here: "**On another occasion, I had to go to therapy, but I had an accident in my brief, and I asked to be changed, but E4 told me to go on to therapy and that she would change me when I returned from therapy. She was on the war path that morning, so I just tolerated her**."

On July 3, 2017, **Family member** (Z1) **said R1 was afraid if she reported E4 for verbal and physical abuse, there would be retaliation by E4 or other staff members**. Z1 said, "**R1 was very afraid of E4. I would prefer you do not interview R1 because she will become very upset. It has taken her quite a few days to get over this situation."** The surveyor noted that R1 was not approached for an interview per her family member's request.

Name of Nursing Home	Meadowbrook Manor
Provider Identification Number	145710
Address	431 West Remington Blvd, Bolingbrook, Illinois, 60440
Investigation Completed	July 5, 2017
Deficiency Citations Issued	F223

Data source	CMS FOIA data; not Nursing Home Inspect website

Case 30 – "Reflexive" Physical Retaliation Against Resident with Severe Cognitive Impairment

The nursing home failed to protect a resident from physical abuse from a staff member. This failure affected R1. R1 was "**severely cognitively impaired"** (based on MDS assessment) and lived with the following diagnoses: **Alzheimer's disease,** Communication Deficit, Dementia with Behaviors, Depression, and Chronic Obstructive Pulmonary Disease.

The Final Report Allegation dated 10/27/16 documents **R1 was hit on the back by E4 Housekeeper** on 10/23/16. R1 was sitting in his wheelchair in the hallway and E4 attempted to move around him. R1 reached out for the doorway that he was passing through and touched E4's thigh. **E4 then slapped R1 on the back** and told R1 to not hit or touch him again. E4 was removed from the building and an investigation followed. Police were notified. R1 was interviewed and could not recollect the incident and did not have any physical injuries from the incident.

On 11/9/16, **CNA (E3)** stated she was in the hallway when she **witnessed E4 Housekeeper smack R1 on the back and yell for R1 to not hit or touch him again**. E3 stated **the smack was** between R1's shoulder blades, **with an open hand**. E3 stated R1 did not react to the smack and when checked, did not have any injuries.

On 11/10/16, Housekeeper (E4) stated he was trying to move past R1 in the hallway and R1 slapped his (E4's) leg. **E4 stated he retaliated by slapping R1 on the back**. E4 denies saying anything to R1.

The facility's Abuse Policy dated August 2016 documents the definition of physical abuse to be, hitting, slapping, pinching, and kicking.

Name of Nursing Home	Hilltop Skilled Nursing and Rehabilitation
Provider Identification Number	145862
Address	910 West Polk Street, Charleston, Illinois, 61920
Investigation Completed	November 10, 2016
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 31 – Request to Remain Anonymous for Fear of Administrator's Retaliation / "*Don't mention my name, because I'm afraid of her*"

The nursing home failed to ensure residents were free from verbal and mental abuse from facility staff for R10 and another resident. R10 lived with depression and "**no impairment with cognition**" (BIMS score of 15 out of 15). The MDS documented she has no behaviors and that she ambulates independently with a wheeled walker.

On 12/07/2016, R10 was **alert and well spoken**. R10 was ambulating independently in her room. R10 stated:

> "**I had talked to one of the activity aides, (E3) about walking to a local store. I need someone to walk with me so I don't fall**. I go out of the building with my walker for exercise. I have walked with someone before. **(E3) said** her boss was gone and **would have to ask the Administrator (E1). (E3) came back and said 'I can't do it.'** Then (E1) walked up behind me and said I couldn't go but could go tomorrow. I said, "I can't go tomorrow." Her (E1) voice kept elevating. She was looking at me sternly. **I felt like a child**. I was getting really upset. (E1) kept saying, "You will go tomorrow!" I went back to my room. Then (E3) came to my room, and I went to the local store and got back shortly after 4:30 PM. It was not dark." "A couple days after the local store incident, I met E1 in the hall in the morning. She looked away from me. E1 did not speak. **I called the corporate hotline and complained about (E1), and (E1) walked into my room the next day and said, 'Don't you ever call that number again**. If you have a problem, come to me.' E1 was very irritated and raised her voice. I said, "I can sign myself out and go outside." (E1) said, **"If you do that, I will have you out of here in 30 days."** "I also called the corporate hotline number related to my internet service that is furnished by the facility for free to any resident. I told E1 my son had checked my computer and said nothing was wrong with it, that the problem is the facility's internet. E1 said, "What does your son know about it?" E1 was very rude through all of this. E1 told me their internet man comes out of Chicago. E1 said, "Do you think he's going to come here. That costs money." Ten minutes later, the maintenance guy (E21) called the internet person and then my internet worked. E1 came in and apologized to me. **I called the corporate hotline related to her rudeness to me**. **She pointed her finger at me in a threatening way**. **I feel threatened every time she talks to me**."

On 12/07/2016, E1 stated:

> "According to (R10), she is able to go and sign herself out and do what she wanted. **I told her if she did that** - go outside by herself that is dangerous, and **I would give her a 30-day notice of discharge for going against doctor's orders.** The CNAs told me she shouldn't go outside by herself. I had told her it's dangerous to go outside by herself. I don't know if she can or not." On 12/09/2016, Activity Aide (E3) reported she was no longer employed at the facility. **E3 stated: "I did overhear the conversation**. R10 wanted to go to the store. I was unaware of the policy if she could go to the store. I went to E1 and she told me it was going to be dark soon and was too late. The local store is not far from the facility. They both (E1, R10) got loud with each other. It wasn't a private area. It was by the nurse's station. **R10 got very embarrassed**. **It was**

definitely a scene. I don't think it was very professional of E1. **She was very stern with R10. Sort of like a mother would talk to a child.** E1 shouldn't have gotten loud with her. **E1 is very rude**. The residents are grown and don't need a mother. E1 finally threw her hands up in the air and said, "Do whatever you want!" **R10 was very upset and crying. E1 was condescending**. She's also very rude to (confidential) resident. I've heard her be rude to her a couple of times."

E3 reported **both R10 and the confidential resident have full capacity to tell you what they know.** E3 reported she did not overhear E1 threatening R10 with a 30-day Notice of Discharge because she left to get her coat to take R10 to the local store.

A resident was asked if she had experienced any inappropriate behavior from staff. **This resident asked to remain anonymous and requested the interview be confidential for fear of retaliation from the new Administrator (E1)**. During the confidential interview, the resident reported **she had spoken to E1 about a concern she had about another resident who was having a problem with a CNA shaking her finger at this resident**. This confidential resident reported E1 "was outside of the facility smoking a cigarette when she approached E1 about her concern. During the confidential interview, the resident stated:

"E1 asked me what I wanted**. I told her what happened with this resident**. When we came back in at lunch time at 11:30 AM-people were lining up. I was going to the dining room. **E1** was up by the dining room. **She grabbed the hood of my jacket and said, 'Doll face, pretty baby, don't you ever do that to me again. If you have anything to say to me, you better come to my office.'** I guess E1 got embarrassed. **She looked at me mean, I was in shock**. It was what she said, her tone of voice, and the way she looked. I told (E1) if a CNA shakes her finger in one person's face, she would do it to another. **E1 was rude, unprofessional**. I told my son. **I felt disrespected when she called me "baby doll" and then "sweetie face**." **I'm not a baby**. E1 could have said to come to her office and let's have a talk. **I love old people. I don't like to see them mistreated. I know now if I open my mouth, I will get in trouble with E1.** I can't take it. It took me by shock that day. I don't like it. **Don't mention my name, because I'm afraid of her**. I'll be nice to her as long as she's here. That's just my nature. I'm just not going to cross E1 or go anywhere she is. **I don't know how much longer I can take this. We have freedom of speech in America."**

The nursing home's investigation Initial Incident and/or Abuse Notification for R10 and the confidential resident found: **An interview from R5** documents **yes to E1 being rude**, and E1 being loud Yes, about wanting to go to (local store). **E23** answered about E1 being rude to a resident, "**Kinda, a couple times**" and **yes to E1 being loud**. An interview with **CNA** (**E22)** dated 12/08/2016, completed by E23 answers **yes to E1 being rude to a resident**, and yes to E1 being loud to a resident.

Name of Nursing Home	Integrity HC of Columbia
Provider Identification Number	145717
Address	253 Bradington Drive, Columbia, Illinois, 62236
Investigation Completed	December 13 2016
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 32 – CNA to Resident with Severe Cognitive Impairment:
"If you hit me, I will have you sedated"

The nursing home failed to protect a resident (R1) from verbal abuse. R1 diagnoses included **dementia**, and **stroke with some paralysis**. R1's MDS showed she was unable to complete the BIMS, and staff determined that R1 is "**severely cognitively impaired"** for daily decision-making. R1's MDS also showed R1 requires extensive assistance for eating.

On December 27, 2016 at 10:40 AM, CNA (E6) stated that on December 12, 2016, she was assisting R1 with eating breakfast. E6 stated when **R1 started refusing to eat any more food,** E6 moved over to sit between R5 and R6, who were also seated at the assistance table. E6 stated that CNA (E3) came over to the table, and **E6 told E3 that R1 did not want any more to eat**. **E6 stated E3 told her she would get her to eat more**. **E6 stated** while she was feeding R1's tablemate, **she heard E3 tell R1, "If you hit me, I will have you sedated**. **I will have you out 24/7."** E6 stated she reported the incident to RN (E4).

On December 27, 2016 at 1:20 PM, CNA (E7) stated that she was assisting other residents at a nearby table in the dining room during breakfast on December 12, 2016. E7 stated she heard E3 say something to R1 like, **"Don't you hit me or I'll have you sedated for 24 hours**." E7 stated she got up from the table and reported the incident to E4 and E5 (two RNs working on unit).

E7 stated, "I am not at all trying to chase someone out. **It's zero tolerance**. **Anytime you hear something close (to abuse), you have to report it. You can't ignore it**."

On December 27, 2016, the Director of Nursing (E1) stated **the threat of sedating is intimidation**. E1 added administration tried to contact E3 multiple times during the investigation and she did not respond until after the investigation was complete. E1 stated E3 denied receiving any calls, voicemails, or the registered letter that was sent.

On December 27, 2016 at 9:00 AM, R1 was asked if she remembered anything unusual during breakfast on December 12, 2016. R1 answered she is not a calculator and had some difficulties following the questions being asked. R1 stated she doesn't like the staff, "not one of them, and she's one of them ain't she?" but it was not clear who she was referring to. R1 was unable to describe any incident on December 12, 2016.

Name of Nursing Home	Sandwich Rehab & HCC
Provider Identification Number	146133
Address	902 East Arnold Street, Sandwich, Illinois, 60548
Investigation Completed	December 28, 2016
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 33 – Retaliation for "*pressing the call light a lot*" / "*Keeping me prisoner*"

The nursing home failed to report an allegation of abuse and separate the alleged staff from resident (R1) care. R1's current Physician's Order sheet shows R1's diagnoses include Falls, Rt. Ulna Fracture, and Glaucoma. R1 was admitted to the facility on 10/17/16 and discharged on 10/29/16. [Expired] R1 has "**no cognitive impairment**" (based on MDS assessment). She requires extensive assistance for transfers and has a range of motion limitations of one upper extremity and both lower extremities. She is always incontinent of bowel and occasionally of bladder. The MDS shows no behavior problems.

On November 10, 2016, CNA (E4) said:

> "On October 22, 2016 at 8:00pm, R1 started **pressing the call light a lot**. **Registered Nurse (E2)** does not have as much patience as I do. E2 **said** not to worry about R1 anymore, **he was going to take her call light away from her**. E2 came out of R1's room. I could hear R1 crying. I went into R1's room and turned on the light. R1 told me, "**E2 is keeping me prisoner, he is holding me captive**." E4 said, "I became very upset, and I did not know what to do. I told CNA (E5) she told me to do what I thought best. I confronted E2 and he became defensive and then I left the facility."

On November 10, 2016, CNA (E5) said:

> "R1 was acting different all evening, she was angry." E5 said that "E2 told her (E5) I just gave her (R1) eye drops and he (**E2**) seemed irritable and **said I'll just take the call light**. E4 told me that R1 was upset. E4 went outside and called her dad and then she went and confronted E2, and then went home. **R1 was upset** and started crying **and asked me (E5) if the bad man was still here**. R1 wanted to make sure the door was open, the lights were on, and she had the call light."

The facility's incident investigation dated October 22, 2016 documents, "**R1 reported** to her CNA that **RN (E2) had moved her call light so it was not in easy reach**, **he shut the light off and closed her door when leaving the room**. The resident did specify that **she does not like to be left alone and does not like the door shut or lights off because it makes her fearful."**

Name of Nursing Home	Alden Debes Rehab & HCC
Provider Identification Number	145142
Address	550 South Mulford Avenue, Rockford, Illinois, 61108
Investigation Completed	November 15, 2016
Deficiency Citations Issued	F225
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 34 – Punched in the Mouth for Yelling for Help

The nursing home failed to prevent verbal and physical abuse from occurring to R1. **This failure resulted in** R1 experiencing sleeplessness and **fearfulness after being punched in the face when calling out for staff assistance.** R1 has "**moderate cognitive impairment"** (based on MDS assessment) and is totally dependent on staff for transferring, toileting and bathing, and requires extensive assistance for bed mobility, dressing and personal hygiene. The MDS also shows R1 is occasionally incontinent of bowel and bladder. R1's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease, atrial fibrillation, glaucoma, diabetes, major depressive disorder, lack of coordination and muscle weakness.

On December 28, 2016, R1 said:

> "On December 14, 2016, **I was yelling for help and CNA (E5) came in my room and said, "What do you want? Shut up!" Then all of a sudden "BAM, BAM, BAM," he punched me in the mouth three times**. **It hurt like heck**. Then he held my hand and said he was so sorry and offered me some chocolate from my drawer and begged me not to report him. **I didn't say anything to anyone that night, but I laid there awake because I was afraid he would come back**. I did not call for help while (E5) was working. I told nurse (E11) in the morning what happened because I did not think that it was right for (E5) to yell at me and punch me when I asked for help."

On December 28, 2016, E11 said:

> "Around 9:00am on December 15, 2016, (R1) told me he was punched by [E5] the previous night. I immediately reported the allegation to the Administrator (E1) and Director of Nursing (E2) and they started the investigation. I did a total body assessment and there was no visible injury, discoloration or swelling on R1's body."

On December 22, 2016, the **police department notified** the facility of **E5's confession of physical abuse towards R1.** On December 28, 2016, police officer (Z1) said he responded to the facility on December 15, 2016 for an allegation of abuse. Z1 said there was no physical evidence of abuse on R1. Z1 said **R1 explained how he was punched by E5 on the evening of December 14, 2016 after calling out for help from his room**. **Z1 said E5 confessed to physically abusing R1 within 4 to 5 days of the incident** and that no arrest was made because neither R1, R2, or R5 pressed charges against E5. Z1 said it was not clear if R2 or R5 understood the legal system due to the language barrier. In addition, **the spouse of another resident with dementia stated she witnessed E5 slap her husband** during a transfer from wheelchair to bed after her husband grabbed E5's arm. The resident was not interviewable due to medical condition, language barrier, and dementia.

Name of Nursing Home	West Suburban Nursing & Rehab Center
Provider Identification Number	145333
Address	311 Edgewater Drive, Bloomingdale, Illinois, 60108
Investigation Completed	January 3, 2017
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 35 – Being Yelled at for Needing Assistance with Bowel Movement

The nursing home failed to ensure that staff did not **verbally abuse** R1. R1 has "**intact cognition"** (based on MDS assessment) and needs total dependence with two assistants for toileting due to bowel and bladder incontinence. R1 diagnoses included Guillain-Barre Syndrome, Major Depressive Disorder, Motor and Sensory Neuropathy, Chronic Pain, and Anxiety.

On October 4, 2016, R1 stated that on September 28, 2016, R1 **had a bowel movement which was causing pain to R1's bottom.** R1 stated that **as CNA (E7) and CNA (E13) entered R1's room that evening, E7 had fire in her eyes. E7 was mad and yelled at R1 for needing assistance during mealtime** while E7 was feeding other residents. R1 stated: "E7 acted like I was a burden. **E7 told us** (R1's spouse was also in the room) **that if I needed one-on-one care, that I should go elsewhere**."

The nursing home Incident Investigation report (dated September 29, 2016), documented by Administrator (E1), that CNA **(E7) was terminated** for improper care and misconduct toward a resident and family member. On October 5, 2016, Administrator (E1), stated, "I didn't feel that E7's actions rose to the level of verbal abuse, but rather, I terminated her for improper care and misconduct of a resident."

Name of Nursing Home	Gilman Healthcare Center
Provider Identification Number	145347
Address	1390 South Crescent Street, Box307, Gilman, Illinois, 60938
Investigation Completed	October 5, 2016
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 36 – Kicking Resident's Wheelchair "really hard" for Leaving Bedroom with No Clothes On

The nursing home failed to ensure that R20 was not subjected to **verbal, mental, and physical abuse** by an employee. R20 has **"moderately independent" cognitive status** (based on MDS assessment) with diagnoses of Schizoaffective Disorder, Agitation and Bipolar Disorder. The resident requires limited assistance of one staff person for dressing and transfers.

The nursing home's Final Report dated December 8, 2016 documents that on December 3, 2016, CNA (E26) was rude to R20, staff intervened and E26 was escorted from the building. The Final Report documents that on December 3, 2016, **R20 exited R20's room with no clothes on wanting E27 Registered Nurse and that E26 walked up to R20 and yelled at R20 and kicked R20's wheelchair**.

The Final Report documented: R20 reported that E26 yelled at R20 because R20 needed help putting on R20's clothes and told R20 to go back to R20's room. R20 said that E26 kicked R20's wheelchair when E26 yelled at R20. Two other residents (R41 and R28) and Activity Assistant (E6) reported that E26 yelled at R20 to go back to R20's bedroom and then kicked R20's wheelchair.

Final Report: "The facility determined that **the allegation is substantiated**. (E26) was terminated."

On January 24, 2017, E6 stated that on December 3, 2016 at approximately 10:30am E6 heard yelling. E6 stated E6 looked up and E26 was yelling at R20 in the hallway. E6 stated R20 turned R20's wheelchair to go back to R20's room and then **E26 kicked R20's wheelchair really hard – enough that R20 rolled to the end of the hallway**. E6 stated E26 looked like **E26 was p***ed off and being aggressive**. E6 stated R20 tried to stop the wheelchair with R20's feet but the wheelchair kept rolling. E6 stated E6 heard E26 **yelling "Get back to your room."** E6 stated E26 used the word **"F**k"** when E26 was yelling at R20. E6 stated that after the incident, E6 went to R20's room to check on R20. E6 stated R20 told E6 that the morning staff refused to help R20 get dressed so R20 did not get to go outside for smoking time. E6 stated that R20 stated R20 was **upset and angry that E26 yelled at R20 and kicked R20's wheelchair**. E6 stated R20 was also **upset that staff would not help R20 get dressed that morning so R20 missed smoking time**. E6 stated **E26 was being abusive towards R20**.

On January 24, 2017, R20 stated that the care staff members are good to R20 except one time when a CNA yelled at R20 and kicked R20's wheelchair. R20 was asked how the incident made R20 feel and R20 stated, "**It's over now, I don't want to talk about it."**

Name of Nursing Home	Palm Terrace of Mattoon
Provider Identification Number	145584
Address	1000 Palm, Mattoon, Illinois, 61938
Investigation Completed	January 26 2017
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 37 – Afraid She'll Get Hurt and "kicked out" for Speaking Up About Emotional/Mental Abuse
The nursing home failed to operationalize their policy for abuse prevention for R2. **This failure resulted in R2 being emotionally/mentally abused** by two employees. R2 described having feelings of worthlessness and **fear due to the incident**. R2 demonstrated ongoing emotional distress as she **trembled and became tearful when describing interactions with the employee perpetrators.** R2 was "**cognitively intact**" (based on MDS assessment) and had the following diagnoses: Bipolar Disease, Obsessive Compulsive Disorder, and Parkinson's Disease. Resident's Care plan last updated January 17, 2017 documents that **R2 "has a habit of picking her skin until it bleeds."**

On March 21, 2017, R2 stated:

> "(E6 and E8) "made me feel worthless. I was crying one day because of those two. **I was more scared of E6**. E6 was aggressive. **"Pick, Pick, Pick, is that all you can do?"** E6 said to me. **They were making fun of me**. I am not dumb. **It is better since they left**. E6 was awful loud. E6 would yell at me you're dirty, get in there and clean up. E8 just kind of followed. Nobody else makes me feel dumb or stupid and I feel safe now. E6 and E8 never talked to me, just to each other about me. I'm not stupid. I raised six kids. **I still wake up and think about it and feel scared**. **I was afraid to say anything at first. I don't want to get kicked out of here**."

On March 21, 2017, R3 stated:
"E6 was rude (to me) a few times. E6 sometimes was loud. She ordered me around and once told me to shut up and do what she said. E8 always followed what E6 said to do."
On March 21, 2017, Registered Nurse (E2) and Director of Nursing (DON) stated:"(E5) came to me (on January 24, 2017) and stated that **(R2) was** upset and **afraid that if she spoke up, they (E6 and E8) might hurt her.** R2 voiced to me (E2) that **she was scared** and that E6 and E8 were both mean and rude. I saw R2 **in tears**. E5 takes care of R2 five days a week and was concerned for R2. R2 and other residents said that when E6 and E8 came to the room to answer call lights they (E6 and E8) would say they would return and then wouldn't. We found them (E6 and E8) to be **emotionally abusive** to R2 and other residents."**All residents interviewed stated the same** behavior from E6 and E8.

According to the facility's final **investigative report** titled "Allegation of Staff to Resident Abuse on January 24, 2017" documents, "**Facility was able to determine that E6 and E8 did verbally abuse R2 by making R2 feel intimidated**. After interviews with staff and alert oriented residents, it appears E6 and E8 do not want to be here and are rude and disrespectful to resident. The facility terminated E6 and E8."

Name of Nursing Home	Bloomington Rehabilitation & HCC
Provider Identification Number	145610
Address	1925 South Main Street, Bloomington, Illinois, 61701
Investigation Completed	March 21, 2017
Deficiency Citations Issued	F226
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 38 – Throwing Bed Sheets Over Resident and Jerking Privacy Curtain "so hard" in Reaction to Walking from Bathroom to Bed Alone / "*I was so afraid, I didn't sleep the rest of the night*"

The nursing home staff failed to report an allegation of potential abuse to the facility abuse coordinator, investigate an allegation of potential abuse, protect a resident from an alleged perpetrator during an abuse investigation and report an allegation of abuse to the state agency for R1.

R1's History and Physical by R1's physician, documents, **(R1) is "a very good historian**." R1's MDS documents R1's mental status as "**Alert/Oriented** to person, place and time."

R1 stated:

> "**I was very afraid after that night. I was afraid E6 was going to come back into the room**. That night, on 10/28/15, around 11:00pm, **I need to go to the bathroom**. I turned my light on and a black CNA helped me to the toilet. **After I finished, I started walking back to my bed with my walker**. **This CNA (E6**) stood in my doorway and **said 'Oh, you're walking around in the dark.'** E6's voice was **so loud and mean**. I sat down on the bed and took some deep breaths, because I was out of breath. **I was attempting to get my legs on the bed and all of a sudden, all I saw were sheets. E6 had threw them up over me**. **Then E6 took the privacy curtain and pulled it so hard, jerked it so that it hit the cupboard and made a loud noise. I thought boy E6 is mad about something.** E6 had come over from another hall to answer call lights. **I was really afraid. I was so afraid; I didn't sleep the rest of the night. I told the day shift nurse about it the next morning**. RN/Day Shift Nurse (E4) said E4 was going to tell the DON (E2). A couple of hours passed, and the DON didn't come talk to me. In the meantime, my daughter came in, so I told her about it. My daughter got the DON (E2) and (E5) RN/ Unit Manager (E5) came in and I told them about it. DON (E2) said, **'That's only your perception.'** The Administrator (E1) never came in to talk to me about it. E1 never questioned me about it."

Don (E2) stated: "**R1 told me that E6 was loud and threatening to R1 and that R1 was afraid.** I didn't tell the Abuse Coordinator (E1) about it, because I thought the situation was resolved." The DON also stated, "I talked to E6 on 10/30/15 and **E6 said E6 didn't mean to scare R1**. I left (the facility) on 10/30/15 and the Administrator (E1) knew about it around 10:00am."

RN (E4) stated s/he asked R1 how the night was, and R1 said, 'Not so good.' **At first, R1 didn't want to discuss it, R1 didn't want to get E6 into trouble.** RN/ Unit Manager (E5) stated, **R1 "kept saying, 'I couldn't sleep. I can't go on like this.'** R1's daughter said, **'R1 doesn't feel safe here and I'm not going to make R1 stay here.'** The Administrator (E1) stated, DON (E2) "told me something about it (incident with R1) on Friday morning. E2 told me the situation was resolved. I didn't do an abuse investigation, I guess I should have. I didn't notify the state (agency)."

Name of Nursing Home	Illini Restorative Care
Provider Identification Number	145703
Address	1455 Hospital Road, Silvis, Illinois, 61282
Investigation Completed	November 5, 2015
Deficiency Citations Issued	F225
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 39 – CNA to Resident: "*Put it away or I will cut it off*," referring to his penis

The nursing home failed to ensure staff did not mentally and verbally abuse R1. R1 was verbally and mentally abused by a staff member when staff made a derogatory statement toward R1. R1 was "**moderately cognitively impaired**" (based on MDS assessment). R1's diagnoses included **Dementia with Lewy Bodies Disease**, Parkinson's Disease**, Vascular Dementia** and Acute Kidney Failure (AKF). The resident has an indwelling catheter due to AKF.

The facility's report titled Report to Department of Public Health dated 3/24/17 documents an incident with R1 and CNA (E6) which took place on 3/22/17. R1's spouse (Z2) reported an incident of inappropriate and unprofessional comment from staff member E6. Review of the investigation done by the facility documents E6 made the statement to R1, **"Put it away (R1's penis) or I will cut it off."**

Z2 stated on 4/12/17:

> "I was in the room when **E6 said to me what was stated to R1 when displaying an inappropriate sexual behavior (masturbation**). **E6 told my husband** (R1), **"Put that away or I will cut it off**." **My husband has Lewy Body Dementia and the doctor told me he could not help what he does, he does not understand what he is doing. I was crying**. Housekeeping supervisor (E3) told me this needed to be reported to the Administrator. The Administrator was in a meeting, so we went to Director of Nurses (E2) and I told her what E6 said to me about R1. [The] Reason I was so upset is that R1 gets scared when he gets his fingernail cut. **My feeling is that he would be very frightened because it sounds like someone is cutting a body part off**."

E3 stated on 4/12/17: "I heard Z2 speaking to the second shift nurse (E8) and Z2 was crying. **I overheard Z2 say,** "**Put that thing away or I am going to cut it off**." The nurse and I stated to each other this has to be reported right away. Z2 stated E6 told her she stated that to her husband. Z2 and I went to report this incident to the Director of Nurses (E2). (E2) took over the investigation.

CNA (E5) stated: "When we (E6 and I) were trying to take care of R1, **E6 was trying to get R1's catheter bag and R1 kept trying to masturbate.** I told R1 to please wait until we were done with his care and out of the room to do this inappropriate behavior. I had his dirty incontinence brief trying to throw it away which was close to the door and R1 started to masturbate again and **E6 stated, R1 "put it away before I cut it off."** I told E6 that was inappropriate to talk to R1 like that. No, I did not report that at that time.

The Director of Nurses (E2) stated, Z2 "came to me to report a concern. Z2 stated that E6 told her what E6 said to R1, "Put it away or I will cut it off." After the conversation with Z2, I reported everything to the Administrator."

Name of Nursing Home	Heritage Health-Normal
Provider Identification Number	145732
Address	509 North Adelaide, Normal, Illinois, 61761
Investigation Completed	April 13, 2017
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 40 – Being Scolded for Not Using Call Light Including Threat to be Sent to E.R. / Director of Nurses to RN Perpetrator:

"Scaring someone to death is not the way to do it (use the call light)"

The nursing home failed to ensure R1 was free from mental and verbal abuse on July 30, 2016. R1's Physician Order Sheet shows, R1 was a new admission to the facility on [late] July 2016 with diagnoses to include anxiety disorder, congestive heart failure, Parkinson's and atrial fibrillation.

On August 8, 2016, R1 stated last weekend (July 30-31, 2016) **a tall nurse came into her room and started yelling at her for not using her call light.** R1 stated, **"I don't know why, I wasn't doing anything wrong. She scared me. She shouldn't yell and scold me. I'm not a child**. Another girl overheard it and reported it and the nurse has been fired." R1 stated she wanted to leave the facility because of the incident but the facility assured her the nurse would not be back so she agreed to stay and continue with therapy. R1 stated she has forgiven the nurse and feels safe in the facility.

On August 8, 2016, CNA (E5) stated she went into R1's room around 11:00pm on July 30, 2016 to answer R1's call light. R1 was walking towards her bed. E5 stated she assisted R1 to bed. **Registered Nurse (E4) came into the room and started yelling**. E4 wanted to know if R1 was in the bathroom. E5 stated she was on her way to bed. **E4 yelled she would call the doctor and tell him R1 would not go home ever because she was unsafe by herself. E4 told R1** that she was not going to be responsible for her falling and **if R1 got out of bed without using her call light she was calling the doctor and would have her taken to the emergency room for not listening**. E5 stated **R1 had** her bed linens pulled up to her neck with **a scared look on her face** and E4 had wild eyed look and was visibly mad. **E4 then took R1's call light and shook it in front of R1 and asked her if she knew what it was. R1 was cowering and softly responded, "Yes**." **E4 told R1 to push the call light (shaking the call light in her face) or she was going to send her to the emergency room**. E4 then left the room. **E5 stated she was shocked** and knew she needed to report the incident to the charge nurse, however E4 was the charge nurse. E5 stated CNA (E16) came on the unit to see if she needed any help. E5 reported the incident to E16 and asked her to tell her nurse (E6).

On August 8, 2016, E4 stated R1 was a huge fall risk. E4 stated she told R1 if she did not use her call light, she was going to call the doctor and have R1 sleep in a recliner by the nurses' station. **E4 stated she did not mean to threaten R1 about using her call light**; she wanted R1 to understand the risk of falling. **E4 stated threatening a resident was abuse**.

On August 8, 2016, Assistant Director of Nurses (E3) stated she talked with **R1** "who **was still upset and crying.** She was worried she did something wrong. I told her she did nothing wrong and it was not her fault. I assured her the nurse would not take care of her again. R2 was upset. She stated E4 yelled at her and was mad at her for using the call light too much."

On August 8, 2016, the Director of Nursing (E2) stated she talked with E4 on July 31, 2016 to ask her what happened. **E2 stated, "It sounds like you (E4) were threatening and yelling at R1**. I need to suspend you and do an investigation. **Scaring someone to death is not the way to do it (use the call**

light).” She stated that she told her she should never have yelled or threatened R1. E4 was terminated for mental and verbal abuse.

The facility's Final Report of Incident to Department of Public Health (August 3, 2016) concluded:

The allegation of mental abuse has been substantiated. The resident was upset and felt threatened and degraded by E4. E4 will be terminated.

Name of Nursing Home	Presence St Joseph Center
Provider Identification Number	145935
Address	659 East Jefferson Street, Freeport, Illinois, 61032
Investigation Completed	August 9, 2016
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 41 – Cursing at Resident with Dementia for Having Hands in Pants

The nursing home failed to remove CNA (E3) from having direct contact with residents after E3 alleged to have verbally abused R10. E3 was allowed to work in direct contact with all residents in the facility, following the alleged verbal abuse, resulting in E3 allegedly verbally and physically abusing R15. This had the potential to affect all 52 residents in the facility. These failures resulted in Immediate Jeopardy.

R15 has diagnoses of Psychosis, Aggressive Behaviors, Delusions, Poor Impulse Control, and Debility. The resident **receives hospice services** for "**Dementia with failure to thrive**."

On October 28, 2014, at 2:30 p.m., CNA (E4) stated:

> "On October 7, 2014, at around 5-5:30 p.m., "CNA (E3) and myself entered R15's room. **R15 had (R15's) hands in (R15's) pants. E3 yelled at R15, 'You nasty mother f*****r, get your hands out of your pants.'** I then left R15's room and went and told the Director of Nursing (DON; E2) what E3 had yelled at R15. E2 did not remove E3 from contact with R15 at that time. E3 was still in the room with R15 when I went and told the DON (E2). I then went, got wash clothes, and returned to R15's room to help E3 change, dress, and get R15 up. R15 was squirmy. **E3 was trying to put R15's pants on**. E3 grabbed R15's leg forcefully, to put the pants on. E3 then **grabbed R15's remote to the bed and hit R15 in the stomach a couple times and hit R15 on the knuckles a few times**. E3 then **called R15 a "Mother f****r" and told me, 'Do not let the residents walk all over you. You have to show them some discipline.'** I then left the room and told the nurse (E8). E8 then notified the Administrator and the Administrator made E3 leave the building."

On October 28, 2014 at 3:30 p.m., the DON stated, "Around the end of September 2014, E3 would go on rounds with the other CNAs and would say, **"These mother f*****s (the residents) will pee themselves just to do it."** E3 would say it loud enough for residents to hear. It could be heard at the nurse's station. I was going to write E3 up, but LPN (E14) talked to E3 regarding the cussing."

On October 28, 2014 at 4:00 p.m., Administrator (E1) stated, "The staff reported to me on October 7, 2014 that E3 flicked R15's hand. E3 admitted to me that E3 did flick R15, so **that is physical abuse** and E3 was terminated. No allegations had been reported to me earlier about E3 calling resident's names. E3 should have been removed from the facility on the first instance of calling (R15) a mother f****r."

Name of Nursing Home	Countryview Care Center – Macomb
Provider Identification Number	146080
Address	400 West Grant Street, Macomb, Illinois, 61455
Investigation Completed	November 6, 2014
Deficiency Citations Issued	F223
Data source	CMS FOIA data; not Nursing Home Inspect website

Case 42 – CNA Orientee Fearful of Retaliation After Witnessing CNA Abuse Resident

The nursing home failed to ensure their abuse policy was followed for R2. The failure resulted in R2 having **water thrown on him** by a staff member while providing care. CNA (V4) stated she got hired a month ago. V4 stated she was on orientation and being oriented by another aide (V5) on the 10pm to 6am shift. V4 stated when they got to their last resident (R2) at about 5:30am, **R2 had to be changed**. V4 stated **V5 was trying to make R2 stand up but he refused**. **V4** stated V5 went into the bathroom, **came out with two plastic cups of water**, **and told R2 he better get up or she would throw the water on him**. V4 thought V5 was playing when she made those remarks. V4 stated as V5 was talking to R2, **she suddenly flipped one cup of water onto R2** and he started to curse at V5. V4 stated she pulled out her cell phone and told V5 she was wrong for doing that to R2. V4 stated she started to record V5 and at the same time told V5 to leave R2 alone. **When V5 threw the second cup of water towards R2's, the water landed on R2's face and neck**. V4 stated she called and got R2's nurse who confronted V5 and told her to clock out and leave the nursing home.

V4 stated she **was scared of V5 and recorded her because she wanted proof that V5 threw the water at R2**. V4 stated she had abuse training but did not know she could not record residents.

CNA (V5) stated she worked the third shift (10pm to 6am). V5 stated the nurse told her to clean R2. V5 stated she was working with orientee V4. V5 stated they went into the room and R2 asked for his wheelchair to get up but then did not want to get up. V5 stated she told R2 since he was not going to get up, she was going to clean him in the bed. V5 stated she grabbed one plastic cup of water to use to wet the towel. V5 stated she asked V4 for the towel and R2 suddenly knocked the cup of water out of her hand. V5 stated V4 then accused her of throwing the water at R2. V5 stated the nurse on duty told her to write an incident statement and punch out. V5 confirms she wrote a statement and punched out. V5 mentioned she had been working at the nursing home for nine months.

LPN (V6) assessed R2 and saw that he had water dripping on his face, neck, and chest. When asked what happened, **R2 told V6 that V5 had thrown water on him**. When CNA (V7) came to the 6am to 2pm shift, V4 approached her and told her that V5 "is a crazy b****" and threw water on R2.

The Director of Nursing (V10) stated that during the course of the abuse investigation, **V4 told them she was scared of V5 and recorded V5 throwing the water because she feared V5 retaliation towards her**. V10 stated they told V4 she did the right thing immediately reporting the abuse, but she did not comply with their policy because she recorded R2. V10 stated V5 was terminated for throwing water at R2. V10 stated V4 told her she was only being a whistleblower but V4 had to be reprimanded for not following the nursing home's policy of recording residents.

Name of Nursing Home	Aliya on 87th
Provider Identification Number	145983
Address	2940 West 87th Street, Chicago, Illinois, 60652
Investigation Completed	May 6, 2022
Deficiency Citations Issued	F600

Discussion

A total of 50 residents in 40 nursing homes were negatively affected during the incidents described in this report (26 residents were described as cognitively intact, and 13 residents had some level of cognitive impairment (information about the cognitive function level of 11 residents was not detailed in the investigation reports). Many residents lived with serious and complex health conditions and required extensive assistance in activities of daily living (e.g., incontinence / changing adult depends, repositioning, transfers, getting to the bathroom, and assistance with toileting and showers). Taken together, many of the residents were physically frail and vulnerable. Their physical dependency on staff for meeting their basic care needs often contributed to their fear of retaliation when voicing care concerns and making mistreatment complaints. Their voices were silenced. *The main findings include:*

- The circumstances surrounding the incidents spanned across varied care-related situations (e.g., call lights, basic requests for assistance [see below], food-related, hygiene care, toileting, showers, rejection of care / treatment, various forms of mistreatment, wrongful discharges).

- Residents experienced fear of retaliation, threats of retaliation (e.g., abuse, physical violence, discharge), perceived retaliation, and actual retaliation when voicing care concerns.

- Residents feared reporting undignified care, rights violations, neglect of care, rough care, verbal, mental, physical, and sexual abuse, and theft of their money. One resident was physically abused but didn't tell anyone "*Because I was afraid a [CNA] was going to retaliate*."

- Residents feared retaliation *after* reporting care concerns, neglect, abuse, and theft of money.

- Scared of retaliation, certain residents asked to remain anonymous when voicing care concerns (e.g., "*Don't mention my name, because I am afraid of her*").

- Several residents were "*extremely fearful*" of retaliation (e.g., "*I feared for my life*;" "*I fear for my life if she loses her job. Like a postal worker, she'd come back and shoot me*"). One daughter said that her father was "*terrified*" of being discharged after complaining about the care.

- Residents living in advanced stages of dementia experienced "reflexive" retaliation (i.e., verbal and/or physical abuse in reaction to rejection of undignified and unskilled personal care).

- Some residents chose not to request assistance with their basic care needs (e.g. to receive a shower; to go to the bathroom) just to avoid the possibility of experiencing retaliation from CNAs. One resident was "*scared to use the call light…so she just peed the bed*."

- Several residents were reluctant or refused to speak with state surveyors about care concerns and mistreatment. When a state surveyor asked a resident about a verbal altercation he had with a CNA (during which the CNA allegedly told him "Shut the f*** up"), he said, "*Now that you are asking me and bringing this up again, what am I supposed to do when you leave? I still must live here. I don't want to talk anymore*." The resident felt scared and at risk of retaliation.

- Residents experienced helplessness ("*She scares me, and I can't do anything about it*."). Several residents cried during or after retaliatory incidents and when asked to recall them. Others couldn't sleep after incidents. One resident couldn't sleep for a "few nights" after a retaliatory discharge threat from an Administrator. After experiencing physically abusive retaliation from a CNA, another one said, "*I was so afraid, I didn't sleep the rest of the night.*"

- Many residents were verbally and physically retaliated against for simple acts and requests. Examples include: borrowing scissors for an art project; a request to stop spraying air freshener in bedroom; requesting a snack or a sub sandwich; a request to be changed; reminding staff they are to receive a shower that day; walking from bathroom to bed alone; leaving their bedroom with no clothes on; recording their own intravenous tubing; and refusing a dialysis treatment).

- The majority of the perpetrators of retaliation were CNAs but nurses (including several Registered Nurses), managers, and Administrators also retaliated against residents. In other cases, residents experienced retaliation from agency staff, housekeeping staff, Activity Aide, Social Services Director, and Assistant Psychiatric Rehabilitation Services Coordinator.

- In at least 15 cases, residents were left unprotected when perpetrators were not immediately suspended pending the outcome of the investigation. In about ten cases, alleged abuse and retaliation were not immediately investigated and/or reported to the State Survey Agency.

Policy Implications

- The findings highlight the need for stronger federal (CMS) and state oversight and enforcement of residents' rights when it comes to voicing care concerns and making mistreatment complaints without fear of retaliation, threats of retaliation, and actual retaliation against them. Retaliation, which is abuse under federal regulations, takes the form of both overt action and neglect of care needs. The findings support the need for stronger internal and external (regulatory) measures for holding perpetrators of retaliation and administrators and owners of nursing homes accountable.

Practical Implications

The findings highlight…

- Most importantly, the critical need for leadership (Owners, Corporate Offices (in nursing home chains), Administrators, and Directors of Nursing) to be at the center of all efforts to address these issues (“*It starts from the top”).* Owners and top administrators determine which actions by employees are, or are not, tolerated within nursing homes. Illinois should consider laws strengthening accountability for owners and administrators, and incentivizing a culture that disavows retaliatory actions.
- The need for staff and managers’ education on residents’ fear of retaliation and actual retaliation against them. In addition, a subgroup of care staff members may not be aware that things they say and do to residents are perceived by residents as retaliation. It is worth mentioning that for over a decade the State of Connecticut has had a law requiring nursing homes to provide annual staff In-Service training on retaliation. In concert with owner accountability, the State of Illinois should consider passing a similar law and expand it to the assisted living sector.

- The need to educate residents, families, and friends about fear of retaliation, threats of retaliation, and actual retaliation and the ways in which they can advocate to address these issues. Examples include: Knowing their rights, understanding what constitutes retaliation / how to identify retaliation (including blatant versus subtle retaliation), knowing nursing homes’ responsibilities, finding an internal advocate, the role of individualized Care Plan meetings, harnessing the power of the Grievance process, knowing that “there is power in numbers,” the role of resident-run Resident Councils, the role of Family Councils, and the ways in which the Long-Term Care Ombudsman Program (LTCOP) can assist them in realizing their rights.

- The need to raise awareness of the critical role of the LTCOP when it comes to addressing residents’ fear of retaliation and actual retaliation against them. A recent quality improvement project examined this role through interviews with 50 Ombudsmen from 32 states. For details, see the report titled *A Bridge Over Scary Water: Ombudsman Program Strategies and Barriers in Addressing Residents’ Fear of Retaliation in Long-Term Care Homes* (Caspi, 2024b). The report is available upon request from the author of this report.

In Closing

Several years ago, the Star Tribune published a story about 80-year-old Marjory Aldrich who was recovering from pneumonia in a nursing home in Minnesota (Serres, 2017b). One day she felt fluid building up in her lungs. She became frightened when the nursing home discontinued giving her antibiotics. When she asked an aide if they could resume her medications, she didn’t receive a response. When she asked a nurse to call a doctor to renew her prescription, the nurse came and slammed a phone against her chest so hard that the resident almost passed out. She said, “*I laid there for 20 minutes, too petrified to move*.” The woman reported the incident to the Health Department the following day, but no investigator arrived or returned her calls. She was later notified by the Health Department that her case had been delayed until later that year. Reflecting on her

efforts to advocate for herself, she "wondered why she bothered to call the state agency instead of 911 or local police." She added, "*This is why no one knows about these crimes. It's not because we don't have a voice. It's because people in power deliberately choose not to listen*."

Cheryl Hennen, Minnesota State Long-Term Care Ombudsman, said, "*This is a human rights issue. Vulnerable adults with complex medical issues are being retaliated against for the simple act of speaking up. Someone needs to take the lead here and stop the practice*' (Serres, 2017a).

Appendix – Ftags

F550 – Resident Rights

F557 – Right to Be Treated with Respect and Dignity

F580 – Notify of Changes

F600 – Freedom from Abuse, Neglect, and Exploitation [or old Ftag F223]

F602 – Free from Misappropriation / Exploitation

F607 – Policy Employee Screening and Training

F609 – Reporting of Alleged Violations

F610 – Investigate/Prevent/Correct Alleged Violation

F835 – Administration

Old Ftag F225 – Not employ / Engage staff with Adverse Actions [equivalent to new Ftag F606]

Old Ftag F226 – Develop / Implement Policies Prohibiting Abuse / Neglect / Misappropriation / Exploitation

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Other Resources

Fact Sheet
Addressing Concerns About Retaliation The National Consumer Voice for Quality Long-Term Care (2024): https://tinyurl.com/ycysxn5f

Educational Video
Voices Speak Out Against Retaliation Connecticut Long-Term Care Ombudsman Program (2010): https://www.youtube.com/watch?v=nNAG-yWBxM8&t=5s

Webinar
Staff Fear of Retaliation in Nursing Homes: An Unexplored Phenomenon (2023) Hosted by Elder Voice Advocates: https://www.youtube.com/watch?v=Mutv1Pl7cf8

"*Whenever you talk about any type of abuse, there's a power dynamic. The person is using that to isolate. They start to carve the person out. They keep them alone. They keep them in fear. And so, when you align with someone, you break some of that dynamic down. And so that is what we would really encourage people. And that's where the role of the Ombudsman comes in too.*"

– Mairead Painter, Connecticut State Long-Term Care Ombudsman