STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145526	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gottlieb Memorial Hospital	701 West North Avenue Melrose Park, IL 60160

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interview and record review, the facility staff failed to immediately report an allegation of abuse to the abuse task coordinator. This applies to 1 of 12 residents (R62) reviewed for abuse in the sample of 12. The findings include: The EMR (Electronic Medical Record) showed that R62, a [AGE] year-old was admitted to the facility on [DATE] from the acute setting of the hospital. R62 had a recent abdominal surgery to repair hernia on 2/17/2024. R62 has other diagnoses that included gout, hypertension, chronic kidney disease, gastric bypass, and morbid obesity. The MDS (Minimum Data Set) dated 3/3/2024 showed R62 was cognitively intact with BIMS (Brief Interview Mental Status) score of 15/15. On 3/04/2024 at 10:18 A.M., R62 was sitting in a lounge chair in her room. R62 said, I was abused, hurt emotionally, felt disrespected and helpless. This PCT (Patient Care Technician) that had worked the night shift on 2/28/24 - 2/29/2024 came into my room early morning of 2/29/2024 when I was sitting in my lounge chair. I always feel cold, so I asked this PCT for a blanket. I don't know the name of this PCT, but I can describe her to you, she was light skinned African American, height of around 5'2, somewhat obese but not much. This PCT did not write her name on the board, I guess she did not want me to know her name. When I asked this PCT for a blanket, she was so nasty, with angry face, did not help placing the blanket on me and I can't move due to my recent surgery, I needed help. The PCT with her arms stretched out towards me with blankets in her hand said in a nasty angry voice here are your blankets! The PCT then asked me what kind of surgery I had, since I cannot help myself. Oh, I felt so helpless. I then asked her to hand me the phone so I could order my breakfast. She then handed my cell phone. She knows that I must use the land line to order breakfast, but I do not know why she handed my cell phone. I told her that I needed the land line phone which I could not reach since the land line phone was behind my bedside table. The PCT took the land line phone and slammed it down on the overbed table that was in front of me. I reported what this PCT did to me to (V5, Registered Nurse) and (V6, Physical Therapist) the morning of 2/29/2024. The surveyor asked V6 to come to R62's room. R62 said to V6 I reported to you what that PCT did to me that day it happened. V6 confirmed and said she did not report the allegation to V1 (Administrator) and V2 (Director of Nursing) because she was busy, and she thought V5 had reported this allegation already. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/2024 at 3:30 P.M., V5 said, I felt that what (V4/PCT) did to (R62) was inappropriate and an investigation was needed to determine abuse. I called (V2) on 3/1/2024 not on 2/29/2023 when (R62) informed me about how rude and nasty (V4) was to her and how (R62) felt she was treated. This might constitute an emotional abuse. I don't know, maybe I need more abuse training. On 3/4/2024 at approximately 12:30 P.M., V1 and V2 were asked if the facility had any allegation of abuse/or any concern /voiced by their patients regarding care that might be suspicious of potential abuse. V1 and V2 said there was no allegation of abuse reported to them and no investigation was held. Surveyor prompted V1 and V2 regarding R62's allegation of emotional abuse that occurred on 2/29/2024 early morning. V1 and V2 identified that the PCT that R62 was referring to was V4. The facility's abuse policy dated 7/10/2023 showed (This facility) is fully committed to the safety and well-being of its patients and strives to continually ensure the protection of patient's rights while maintaining their safety. The purpose of this policy is to describe the process used to investigate and remediate patients' or visitors' allegations of abuse or neglect by staff or employee . Procedure: 1. Reporting: Employees are required to immediately report any occurrences of potential abuse or injury they observe, hear about or suspect towards a patient to their department manager or Administration The employee who witnessed or was made aware of the allegation is additionally responsible for completing and incident report .2. Notification: Notify risk management of any occurrences of potential abuse . Risk management will initiate a quality investigation and follow up process .Risk Management reports to IDPH (Illinois Department of Public Health) within 24 hours of allegation .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interview and record review, the facility failed follow their abuse policy to suspend the alleged perpetrator and initiate an investigation for an allegation of abuse in a timely manner. This applies to 1 of 12 residents (R62) reviewed for abuse in the sample of 12. The findings include: The facility's abuse policy dated 7/10/2023 showed, (This facility) is fully committed to the safety and well-being of its patients and strives to continually ensure the protection of patient's rights while maintaining their safety. The purpose of this policy is to describe the process used to investigate and remediate patients' or visitors' allegations of abuse or neglect by staff or employee . Procedure: 1. Reporting: Employees are required to immediately report any occurrences of potential abuse or injury they observe, hear about or suspect towards a patient to their department manager or Administration The employee who witnessed or was made aware of the allegation is additionally responsible for completing and incident report .2. Notification: Notify risk management of any occurrences of potential abuse . Risk management will initiate a quality investigation and follow up process. 5. The safety of the victim will be secured by a) Immediately removing the involved staff from further contact . b.) the staff will be removed from further patient contact .9.) External Reporting . Risk Management reports to IDPH (Illinois Department of Public Health) within 24 hours of allegation . The EMR (Electronic Medical Record) showed R62, a [AGE] year-old was admitted to the facility on [DATE] from the acute setting of the hospital. R62 had a recent abdominal surgery to repair hernia on 2/17/2024. R62 has other diagnoses that included gout, hypertension, chronic kidney disease, gastric bypass, and morbid obesity. The MDS (Minimum Data Set) dated 3/3/2024 showed R62 was cognitively intact with BIMS (Brief Interview Mental Status) score of 15/15. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/04/2024 at 10:18 A.M., R62 was sitting in a lounge chair in her room. R62 said, I was abused, hurt emotionally, felt disrespected and helpless. This PCT (Patient Care Technician) that had worked the night shift on 2/28/24 - 2/29/2024 came into my room early morning of 2/29/2024 when I was sitting in my lounge chair. I always feel cold, so I asked this PCT for a blanket. I don't know the name of this PCT, but I can describe her to you, she is light skinned African American, height of around 5'2, somewhat obese but not much. This PCT did not write her name on the board, I guess she did not want me to know her name. When I asked this PCT for a blanket, she was so nasty, with angry face, did not help placing the blanket on me and I can't move due to my recent surgery, I needed help. The PCT with her arms stretched out towards me with blankets in her hand said in a nasty angry voice here are your blankets! The PCT then asked me what kind of surgery I had, since I cannot help myself. Oh, I felt so helpless. I then asked her to hand me the phone so I could order my breakfast. She then handed my cell phone. She knows that I must use the land line to order breakfast, but I do not know why she handed my cell phone. I told her that I needed the land line phone which I could not reach since the land line phone was behind my bedside table. The PCT took the land line phone and slammed it down on the overbed table that was in front of me. I reported what this PCT did to me to (V5, Registered Nurse) and (V6, Physical Therapist) the morning of 2/29/2024. The surveyor asked V6 to come to R62's room. R62 said to V6, I reported to you what that PCT did to me that day it happened. V6 confirmed and said she did not report the allegation to V1 (Administrator) and V2 (Director of Nursing) because she was busy, and she thought V5 had reported this allegation already. On 3/4/2024 at approximately 12:30 P.M., V1 and V2 were asked if the facility had any allegation of abuse/or any concern /voiced by their patients regarding care that might be suspicious of potential abuse. V1 and V2 said there was no allegation of abuse reported to them and no investigation was held. Surveyor prompted V1 and V2 regarding R62's allegation of emotional abuse that occurred on 2/29/2024 early morning. V1 and V2 identified that the PCT that R62 was referring to was V4. V2 said that on 3/1/2024 around 7:45 A.M., V5 reported to her that V4 was nasty/rude to R62 and that R62 wanted to talk to her. V2 said that she tried to call R62 the same day (3/1/2024) but R62 did answer her phone. V2 added that she did not come to see R62 for a follow up and did not initiate an investigation till 3/4/24 at 12:30 PM. On 3/4/2024 at 5:30 P.M., together with V2, R62 was interviewed. R62 said, I was hurt and emotionally abused, disrespected and felt so helpless because of (V4's) treatment of me. R62 said V4 slammed the phone in front of her, was not gentle when she handed me the blankets and said here! V2 apologized for not following up with R62 on 3/1/24, 3/2/24, and 3/3/2024 nor had asked any managers on duty when she was not able to contact R62 on 3/1/2024. On 3/4/2024 at 3:30 P.M., V5 said, I felt that what (V4/PCT) did to (R62) was inappropriate and an investigation was needed to determine abuse. I called (V2) on 3/1/2024 not on 2/29/2023 when (R62) informed me about how rude and nasty (V4) was to her and how (R62) felt she was treated. This might constitute an emotional abuse . On 3/6/2024 at 3:00 P.M., V1 said, If (R62) said she was abused, then we considered it as an abuse and an immediate implementation of abuse policy should have been done that included investigation, suspension/protection and reporting. The facility's schedule showed V4 worked the night shift on 3/3/24 and this was also confirmed by V2.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 32935 Based on observation, interviews, and record review, the facility failed to post the daily staffing information so it can be read by residents and family. This affects all 22 residents residing at the facility at the time of the survey. On 3/4/2024 at 12:35pm, the Nurse staffing was posted on the wall behind the Nurses station above eye level while standing. The staffing information was on a sheet of paper inside a plastic page protector that reflected the overhead lights to obscure the writing on the page. Additionally, the paper was purple with black print and handwriting, creating a dim contrast. The information on the staffing sheet was not readable. On 3/5/2024 at 10:50am, the daily staff posting had been updated and was on purple paper posted behind the Nurse's station and above eye level. On 3/5/2024 at 10:52am, R66, wearing eyeglasses, was in a wheelchair working with Physical Therapist. At that time, R66 was wheeled as close to the Nurses Station as possible and tried to read the daily staffing sheet but was unable to do so. R66 cited the reflection of the lights and the distance. According to the most recent MDS (minimum data set) dated 3/5/2024 for R66, R66 is cognitively intact and requires moderate assist from one person for transfers. On 3/5/2024 at 1:45pm, V1 (Administrator) stated she agreed the daily staffing posting was difficult to read.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 16746 Based on observation, interview, and record review, the facility failed to follow standard infection control practices related to hand hygiene and gloving during medication administration. This applies to 2 of 3 residents (R64 and R220) observed during medication pass administration in the sample of 12. The findings include: 1. On 3/4/2024 at 1:09 PM, V15 (Registered Nurse) went inside R64's room to administer the resident's IV (intravenous) medication. While inside R64's room, V15 put on a new pair of gloves, then used the computer mouse, computer bar code scanner to scan the IV medication (inside the syringe), placed the IV medication (Cefazolin 2 grams injection) on top of the medication cart and held/close the medication cart drawer. While wearing the same gloves, V15 cleaned R64's PICC (Peripherally Inserted Central Catheter) line lumen (single). After cleaning the PICC line lumen, V15 got the IV medication (from the top of the medication cart) and was about to administer the said medication via the PICC line. V15 was asked if she was ready to give the IV medication and she responded, yes. V15 was asked to step out of R64's room. While outside of R64's room, V15 was prompted to remove her used gloves, perform hand hygiene and apply a new pair of gloves then reclean the PICC line lumen, before continuing to administer the IV medication. 2. On 3/6/2024 at 9:50 AM, V10 (Registered Nurse) and V16 (Registered Nurse orientee) put on their gown and gloves to enter R220's room to administer the resident's medication. V10 and V16 were already wearing their mask. V10 stated R220 was on contact precaution due to history of ESBL (Extended Spectrum Beta-Lactamase). V10 with her gloved hands, prepared (removed from packaging) R220's oral medications consisting of eight (8) different tablets and/or capsules and placed then all together inside the medication cup. The prepared oral medications included Metoprolol 50 mg (milligram), 1 tablet and Entresto 24 mg/26 mg, 1 tablet. After preparing the said oral medications, V10 was handing the said medication cup to R220. R220 requested to have his blood pressure be taken again because he does not want to take his blood pressure medications if his blood pressure was low. V10 got the blood pressure cuff that was hanging on the foot part of R220's bed, attached it on the blood pressure machine, applied the blood pressure cuff on the resident's arm, placed the pulse oximeter on the resident's finger and pressed the machine to start. R220's blood pressure registered at 102/62. V10 handled the computer mouse to check the computer for pictures and markings of the medications to hold (not to give) as ordered due to low blood pressure result. With the same gloves that she (V10) used during the entire medication administration procedure (described above), including blood pressure monitoring, V10 took out the Entresto and Metoprolol tablets from inside the medication cup, then administered the rest of the medications to R220. Again, with the same gloves, V10 proceeded to open R220's Spiriva 18 mcg (microgram) capsule packet, held the capsule with the same gloves and placed the capsule inside the inhaler chamber and handed the inhaler to the resident to administer the Spiriva inhaler. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2024 at 10:05 AM, V10 and V16 were inside the nursing station and were informed of the infection control concerns. V10 acknowledged that she used the same gloves all throughout the medication observation from preparing R220's medications, taking R220's blood pressure, taking out the two (2) medications from the medication cup and handling/placing the inhaler capsule to the inhaler chamber. V10 stated she should have removed her gloves, washed her hands and applied a new gloves before picking out the two medications and handling the inhaler capsule, to prevent cross contamination and to maintain infection control. On 3/6/2024 at 10:12 AM, V2 (Director of Nursing) stated that after V15 handled the computer mouse, bar code scanner and drawers, V15 should have removed her gloves, washed her hands or sanitized then re-gloved before handling R64's PICC line for IV medication administration. V2 stated V10 should have removed her gloves, washed her hands or sanitized and then re-gloved after handling the blood pressure machine and computer mouse before taking out the medications from the medication cup and before handling the inhaler capsule. V2 stated for any procedure from dirty to clean, the nursing staff should remove their gloves, perform hand hygiene either washing hands or sanitizing and then put on a new gloves to maintain infection control and prevent cross contamination. The facility's policy regarding infection control-hand hygiene last reviewed on 7/31/2023 showed under purpose, Hand hygiene is the single most important measure used in health care worker practice to reduce the risk of transmitting pathogenic organisms. Incorporating an antiseptic agent into the hand hygiene process reduces bacterial counts on hands thus reducing potential morbidity and mortality from healthcare-associated infections. The same policy showed in-part, C. Hands may be decontaminated by washing with antiseptic soap and water or using a hospital approved, alcohol-based waterless antiseptic handrub/hand gel: .4. Before donning non-sterile gloves, 5. After contact with a patient's intact skin ([for example], taking a pulse or blood pressure, or lifting a patient), 6. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient, 7. After removing gloves, .10. After contact with blood, body fluids or other contaminated surfaces. E. The use of gloves does not replace the need of hand hygiene. Hands often become contaminated despite glove use; therefore, hand hygiene must be performed before and after removal of gloves.