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COURTYARD ESTATES OF KNOXVILLE	415 EAST MAIN STREET KNOXVILLE, IL 61448

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A 000	Initial Comment Orignal Complaint Investigation #2525374/IL194705 - No violations. Facility Reported Incident IL194884 - 295.4000 a) b) 295.3020 c) 294.4060 i) 2) A) C) 295.6000 a) 1) 13) 295.6010 a) b)	A 000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Section 295.3020 Employee Orientation and Ongoing Training c) Each manager and direct care staff member shall complete a minimum of 8 hours of ongoing training, applicable to the employee's responsibilities, every 12 months after the starting date of employment. The training shall include: 1) Promoting resident dignity, independence, self-determination, privacy, choice, and resident rights; 2) Disaster procedures; 3) Hygiene and infection control; 4) Assisting residents in self-administering medications; 5) Abuse and neglect prevention and reporting requirements; and 6) Assisting residents with activities of daily living. Violation	A3020		

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A3020	Continued From page 1 These requirements were not met as evidence by: Based on interview and record review, the establishment failed to have staff complete ongoing training for one (E3) of two employees reviewed for training. This could affect all 31 residents residing in the establishment. Findings include: E3's (CNA/Certified Nursing Assistant) personnel file including ongoing training was reviewed with no ongoing training for at least the last year found. On 6-26-25 at 2:45 pm, E2 (Director of Nursing) stated she could not find evidence that E3 had completed ongoing training. The establishments 12/24 Abuse, Prevention, & Prohibition Policy documents "Facility staff shall be trained on the Abuse Prohibition Program during orientation, annually and ongoing during educational sessions, and per state regulations." The establishment's abuse investigation documents on 6-9-25, during the second shift prior to dinner, E3 yelled at R1, grabbed her arm, and made R1 eat her dinner in her room with the door shut. E3 was terminated for abuse.	A3020		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by:	A4000		

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A4000	Continued From page 2 Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. b) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition. Violation These requirements were not met as evidenced by: Based on interview and record review the establishment failed to ensure physician assessments were completed prior to admission and for a significant change for two (R2 and R3) of three residents reviewed for physician assessments in a sample of five. Findings include: 1. R2's face sheet documents R1 admitted to the establishment on 11-12-2024. R2's clinical record does not include any physician assessment. 2. R3's face sheet documents R3 was admitted	A4000		

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A4000	Continued From page 3 to the establishment on 8-7-24. R3's clinical record contains a physician assessment dated 7-30-24. R3's record contains another physician assessment dated 3-18-25 marked as a significant change of condition. This assessment has not been signed by R3's physician. On 6/27/25, at 11:25 am, E1 Executive Director confirmed they do not have a physician assessment completed for R2 before or since her admission and R3's significant change physician assessment has not yet been obtained.	A4000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs i) Training requirements for individuals working in a special program: 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: i) basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders; ii) techniques for creating an environment that minimizes challenging behavior;	A4060		

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A4060	Continued From page 4 iii) identifying and alleviating safety risks to residents with Alzheimer's disease; iv) techniques for successful communication with individuals with dementia; and v) residents' rights. C) Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include: i) assessing resident capabilities and developing and implementing service plans; ii) promoting resident dignity, independence, individuality, privacy and choice; iii) planning and facilitating activities appropriate for the dementia resident; iv) communicating with families and other persons interested in the resident; v) resident rights and principles of self-determination; vi) care of elderly persons with physical, cognitive, behavioral and social disabilities; vii) medical and social needs of the resident; viii) common psychotropics and side effects; ix) local community resources; and x) other related issues. Violation These requirements were not met as evidenced by: Based on interview and record review, the establishment failed to have employees complete the required four hours of dementia specific training for one (E7) and the 12 hours of continuous education regarding Alzheimer's	A4060		

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A4060	Continued From page 5 dsease for (E3), two of two employees reviewed for Alzheimer's education. This could affect all seven residents residing in the establishment. Findings include: 1. E7's personnel file including orientation training was reviewed. This file did not contain the required four hours dementia specific training. On 6-27-25 at 10:20 am, E2 (Director of Nursing) stated E7 has been working alone on the dementia unit. E2 verified E7 has not had the required dementia training. 2. E3's (CNA/Certified Nursing Assistant) personnel file including ongoing training was reviewed with no ongoing training for at least the last year found. On 6-26-25 at 2:45 pm, E2 (Director of Nursing) stated she could not find evidence that E3 had completed ongoing training. The establishment's abuse investigation documents on 6-9-25, during the second shift prior to dinner, E3 yelled at R1, grabbed her arm, and made R1 eat her dinner in her room with the door shut. E3 was terminated for abuse.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the	A6000		

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A6000	Continued From page 6 Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Violation These requirements were not met as evidenced by: Based on interview and record review the establishment failed to prevent abuse and report abuse to representative and physician for one of one resident (R1) in the sample of seven. Findings include: The Establishments undated Abuse Policy and Procedures documents Abuse as: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." "Willful as defined in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." This policy also documents the following: "Mental abuse includes but is not limited to, humiliation, harassment, and threats of punishment or deprivation." "Verbal abuse is defined as the use of oral, written, or gestured	A6000		

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language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability;" "Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking;" and "Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative." This same policy documents resident abuse is to be reported to reported to the Administrator immediately, the resident's legal representative will be notified, and investigation is to be initiated by the Administrator. Administrator will ensure all required agencies are notified, thoroughly investigate all alleged violations, complete a final report and submit to required agencies. The Administrator is to keep the report in a locked file in the Administrators office.

The Abuse Allegation Report for R1, documents on 6/10/25 at 12:45 PM, E6 Housekeeper/CNA (Certified Nursing Assistant) reported to E4 BOM (Business Office Manager) that R1 was "allegedly mentally abused, verbally abused, physically abused, and involuntary secluded to (R1's) apartment by E3 Former CNA on 6/9/25 on the evening shift prior to dinner meal. The interview statements from R2, R3, and R4 document E3 Former CNA yelled at R1 on 6/9/25 for R1 attempting to take a box of tissues from the common area to R1's apartment. R2 through R4 report that E3 Former CNA accused R1 of stealing the tissues and E3 Former CNA and R1 began shouting and grabbing one another's arms. "Witnesses stated the interaction ended with (E3 Former CNA) ordering R1 to go to (R1's) apartment." E3 Former CNA closed R1's

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A6000	Continued From page 8	A6000		

bedroom door "and made (R1) eat dinner in her apartment alone." This report also documents E3 Former CNA admitted to the allegations and subsequently terminated.

The Investigation documents R3 "was visibly shaken and nervous." R2 stated "she didn't want to be in trouble for telling (staff)" and continued to say R1 dropped a box of tissues which E3 Former CNA picked up and when R1 stated "that is mine" E3 Former CNA stated "Only because you stole it" and refused to the tissues to R1. R1 loudly and repeatedly stated that is mine. E3 Former CNA told R1 she could not yell at her and the "arguing continued and rose to a levelthat was upsetting to other residents." R4 reported E3 Former CNA and R1 had hands on each other's arms during the argument. R2 stated E3 Former CNA "forced (R1) into (R1's) room saying 'If you are going to yell at me you can eat in your room and stay there." R2, R3, and R4 stated "that they dread when (E3 Former CNA) is coming in because (E3) yells at them and they feel like if they ask for anything she is going to punish them."

The Establishments initial abuse notification to the State Agency, is dated 6/12/25 and the final notification is dated 6/17/25.

On 6/27/26 at 10:20 AM, E6 Housekeeper/CNA stated R2 and R4 reported to (E6) on 6/10/25, the day after, that E3 Former CNA was yelling and hollering at R1 before dinner about picking up a tissue box from the common area to take to (R1's) room. E3 Former CNA grabbed R1's arms, had R1 go to and stay in her apartment.

On 6/27/25 at 10:25 AM, E6 Housekeeper/CNA stated there was another incident with E3 Former

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A6000	Continued From page 9 CNA and R5. E6 stated she reported to E10 Former Administer that R5 was pointing at E3 CNA and screaming "that's the man who hit me. He did it, he did it." E3 Former CNA was sent home, E6 Housekeeper/CNA covered E3's shift, and for days after R5 was still asking "Is that man here." E6 Housekeeper/CNA stated she does not know if there was an investigation completed for that incident. On 6/27/25 at 11:40 AM, E8 Vice President of Operations, stated the 6/9/25 allegation of abuse for R1 was reported to E10 Former Administrator on 6/10/25 and E10 did not report to the State Agency. E2 DON/Director of Nursing initially reported to the State Agency on 6/13/25. E8 confirmed the allegation of physical abuse, mental abuse, verbal abuse, and involuntary seclusion was substantiated and E3 Former CNA's employment was terminated.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months	A6010		

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A6010	Continued From page 10 after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident; 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. These requirements were not met as evidenced by: Based on interview and record the facility failed to report to the State Agency an allegation of abuse for two residents (R1 and R5) and investigate an allegation of abuse for one (R5) in the sample of five. Findings include: The Establishments undated Abuse, Prevention,	A6010		

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A6010	Continued From page 11	A6010		

and Prohibition policy and procedures documents resident abuse is to be reported to the Administrator immediately, the resident's legal representative will be notified, and investigation is to be initiated by the Administrator. The Administrator will ensure all required agencies are initially notified, thoroughly investigate all alleged violations, complete a final report, submit the final report to required agencies, and keep the report in a locked file in the Administrators office.

1. The Abuse Investigation for R1, documents an allegation of abuse was made on 6/10/25 that occurred on 6/9/25. R1's Physician, POA (Power of Attorney), and State Agency were not notified until 6/13/25.

The Progress Note for R1, dated 6/13/25, documented by E2 DON (Director of Nursing) documents "DON notified of alleged abuse allegation involving this resident. DON assessed resident upon return to facility. No skin issues noted and resident at baseline. DON notified Provider and POA. Regional team aware and (State Agency) notified."

The Establishments initial abuse notification to the State Agency for R1's 6/9/25 abuse allegation, is dated 6/12/25, was sent on 6/13/25, and the final notification is dated 6/17/25.

On 6/27/25 at 11:40 AM, E8 Vice President of Operations, stated the 6/9/25 allegation of abuse for R1 was reported to E10 Former Administrator on 6/10/25 and E10 did not report the allegation to the State Agency within 24 hours. E2 DON initially reported to the State Agency on 6/13/25. E8 confirmed the allegation of physical abuse, mental abuse, verbal abuse, and involuntary

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A6010	Continued From page 12 seclusion was substantiated for R1 and E3 Former CNA's employment was terminated. 2. On 6/27/25 at 10:25 AM, E6 Housekeeper/CNA (Certified Nursing Assistant) stated there was another incident with E3 Former CNA and R5. E6 stated she reported to E10 Former Administrator that R5 was pointing at E3 CNA and screaming "that's the man who hit me. He did it, he did it." E3 Former CNA was sent home, E6 Housekeeper/CNA covered E3's shift, and for days after R5 was still asking "Is that man here." E6 Housekeeper/CNA stated she does not know if there was an investigation completed for that incident. The Establishment was unable to provide any documentation or investigation for R5's allegation of abuse. On 6/27/25 at 11:40 AM, E8 Vice President of Operations, stated the facility does not have any abuse investigations regarding R5 and E8 Vice President of Operations is unaware of any abuse allegations for R5.	A6010		