Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005714	A. BUILDING: _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LONG GROVE REHAB &HC CTR	2308 OLD HICKS ROAD LONG GROVE, IL 60047

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S 000	Initial Comments Complaint Investigation #1916677/IL 115624 Complaint Investigation #1916874/IL 115845	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care	S9999	**Attachment A** **Statement of Licensure Violations**	

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and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical abuse for one of five residents (R1) reviewed for abuse in the sample of 5. This failure resulted in R1 being punched multiple times in the face, falling to the floor, and being dragged by his feet. Since the incident R1 has not been able to ambulate.

The findings include:

On September 16, 2019 at 9:25 AM, R1 was in the secured memory care unit in the dining room. His head was resting on the table. V6 (Certified Nursing Assistant) asked R1 to wake up, R1 lifted his head then put it back down on the table. R1's left ear was dark purple, enlarged and swollen. A dark purple bruise was under his left eye, the left side of his neck was completely covered with a

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dark purple bruise, and he had multiple bruises throughout his arms and hands. At 9:35 AM, V14 (CNA) wheeled R1 to his room. R1 stated, "I'm not feeling good." Dried blood splatter was on his shoes. V4 attempted to transfer R1 back to bed. R1 stood up several times then sat back in his wheelchair; he was unable to stand and transfer. V14 said R1 used to walk all the time, I'm not sure what happened.

On September 16, 2019 at 2:10 PM, V10 (Housekeeping) said on September 5, 2019 she heard a scream and went to R2's room. She found R1 on the floor with R2 grabbing his heels. She said she told R2 to stop, but he did not listen. V10 said she then went to get help.

On September 17, 2019 at 8:45 AM, V15 (Activity Aide) said on September 5, 2019 he was in the dining room when he heard V10 call out for help. When V15 entered R2's room R1 was on the floor bleeding from his ear. R2 was trying to drag R1 out of his room by his feet. V15 said R2 was "very irritated" he was screaming at R1. R2 said he hit R1 because he wouldn't leave his room. V15 said R1 is confused and wanders a lot into other resident's rooms, he needs to be re-directed.

On September 16, 2019 at 12:12 PM, V8 (CNA) said on September 5, 2019 he heard V10 calling out for help. When I got to R2's room. R1 was on the floor. R2 was standing next to R1. R2 said he was upset R1 was in his room and R2 said he hit R1. V8 said R2 usually keeps his door shut, but I'm not sure what happened. V8 said R2 likes to be by himself, he has a private room because he did not get along with other residents. V8 said R1 would walk the halls independently and wander into other residents' rooms.

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On September 16, 2019 at 12:57 PM, V4 (Licensed Practical Nurse) said she was R1's nurse on September 5, 2019. V4 said she was on break and staff alerted her there was altercation between R1 and R2. V4 said when she entered the room, R1 was on the floor, and he was bleeding from his left ear, and had multiple skin abrasions, and redness to his neck. R2 said R1 went to into his room and threw soup on R2. R2 told V4 he hit R1 several times. V4 said R1 was sent out the local hospital and returned to the facility. He sustained a hematoma to his left ear and abrasions. V4 said R2 was sent out to the local behavioral health hospital for aggression and has not returned to the facility. V4 said R2 was very territorial and has a history of verbal aggression.

On September 16, 2019 at 9:19 AM, V6 (CNA) said R1 used to walk independently daily, since the incident he has not been able to walk.

The Abuse Investigation Dated September 5, 2019 documents R1 and R2 reside on a secured dementia unit. Staff observed R1 on the floor with R2 attempting to move R1 out of his room. Staff separated the residents and placed on one to one supervision. R2 said he hit R1 for not leaving his room. R1 sustained a laceration to his lower eye and open skin tear to his left ear. R1 was sent out to the hospital for evaluation. R2 was sent out to a behavioral health hospital. The physician and families were notified. The police interviewed both residents.

R2's Interview statement dated September 5, 2019 states, He was lying in bed, watching TV and R1 came into his room. R2 said he told R1 to get out of his room twice. R2 told R1 he better

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gets out or he would make him get out. R2 said R1 grabbed the soup and threw it him. R2 said he punched R1 a few times, "I don't know how many." Then R2 dragged R1 out and the other guy came and broke it up.

The hospital records dated September 5, 2019 shows R1 sustained a hematoma to his left ear, and skin tears to his left hand and left cheek.

R1's Physician Order Sheets dated through September 2019 shows he is an 85-year-old male residing in the secured memory care unit.

R1's Minimum Data Set assessment dated July 17, 2019 shows his cognition is impaired and he requires supervision when he is walking and requires assistance with his activities of daily living.

R2's Physician Order Sheets shows he has a diagnosis including restlessness and agitation, anxiety, vascular dementia with behavioral disturbance, mood disorder, and alcohol abuse. R2's updated care plan shows he has anxiety with observed symptoms of agitation. R2 has had episodes of verbal aggression, and on November 2018 he became agitated and reported homicidal ideation toward a family member. On September 5, 2019 he became physically aggressive toward another resident. Interventions include to monitor the effectiveness of his medication treatments, avoid over and under stimulation, and encourage an exercise routine that expends energy. The P.O.S. shows orders for Depakote (mood stabilizer) 250 mg twice a day.

On September 16, 2019 at 10:11 AM, V4 (LPN) said V16 (R2's POA) reported to me a few days before the incident he was concerned about

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increased aggressive behaviors in R2.

On September19, 2019 at 9:30 AM, V16 (R2's POA) said his dad has a history of verbal aggression. V16 said he notified V4 (LPN) a few days before the altercation he noticed a behavior change in R2. "I'm noticing something different." R2 was calling multiple family members more anxious and reported this to V4. V16 said V4 told him R2's mood stabilizer medication was decreased recently. V16 said this was "distressing" to me, V17 (Physician Assistant) did not notify me of this change. V16 said he called V17 and expressed his concern about decreasing R2's mood stabilizer medication. V16 said V17 told him she was not going to increase R2's mood stabilizer medication back to the original dose. Then a few days later I get call from the facility that my dad got into a "fist fight." Since R2 has been hospitalized they increased his mood stabilizer medication to his regular dose and he's been fine.

On September 19, 2019 at 12:25 PM, V18 (Nurse Practitioner) said On September 3, 2019, she was covering for V17 (Physician Assistant). V18 said it was reported to her R2's mood stabilizer was addressed by V17 about a week ago and family reported increased behaviors for R2.

The Psychiatric Evaluation dated September 3, 2019 by V18 (Nurse Practitioner) documents R2's chief complaint shows V16 (R2's POA) is requesting psych services. As per staff (R2's) been lethargic so his mood stabilizer was decreased he has been calling the family more, wanting to leave anxious (R2) has been refusing lab draws his mood stabilizer could not be determined." R2 has been more alert since his mood stabilizer has been decreased. R2 was

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S9999	Continued From page 6 observed restless and elevated today. The same reports show he was receiving Depakote (mood stabilizer) 500 mg twice a day. The Involuntary Petition dated September 5, 2019 documents R2 hit another resident (R1) in the face. (R1) did not have any behaviors towards R2. R2 has psych diagnoses of dementia, mood disorder, depression, and anxiety. R2 gets verbally aggressive towards others. On September 16, 2019 at 12:45 PM, V5 (Memory Care Director) said R2 was sent out to an inpatient psych hospital on September 5, 2010 for aggression. R2 remains hospitalized and has not returned to the facility since the incident (11 days). V5 said R2 has a history of verbal aggression, R2 did not do well with having a roommate. He was moved to a single room as intervention for his verbal aggression. The facility's Abuse Policy dated June 2019 states, "The facility affirms the right of our residents to be from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion ...." (B)	S9999		