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
	IL6002463	A. BUILDING: ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALUD WELLNESS	306 NORTH LARKIN AVENUE JOLIET, IL 60435

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S 000	Initial Comments Complaint Investigation 2177298/IL138837	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240f) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were not met as evidenced

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by:

Based on observation, interview, and record review, the facility failed to ensure a resident was free from resident-to-resident physical abuse. This failure resulted in the facility seeking medical attention at the local hospital for R1, and R1 sustaining bruising and abrasions to her nose and face.

This applies to 1 of 3 residents (R1) reviewed for resident-to-resident physical assault in the sample of 3.

Findings include:

On October 5, 2021 at 10:25 AM, R1 was lying in bed. R1 had dark blue to purple bruising over the bridge of her nose, extending under her lower right eye, and bruising and scabbed abrasions across her left lower jawline. Due to her cognitive impairment, R1 was unable to recall how she sustained the injuries to her face. R1 was alert and oriented to her name only. R1 touched the affected areas with her hand and said the areas were painful when she touched them.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility in October 2018 with multiple diagnoses including dependence on renal dialysis, edema of left orbit, diabetes, dementia without behaviors, urinary tract infection, gastrointestinal hemorrhage, diverticulosis, chronic pain, transient cerebral ischemic attack, and end-stage renal disease.

R1's MDS (Minimum Data Set) dated June 24, 2021 shows R1 has moderate cognitive impairment, requires extensive assistance by two facility staff members for transfers between

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S9999	Continued From page 3 surfaces, extensive assistance by one facility staff member for bed mobility, locomotion on and off the unit, dressing, toilet use and personal hygiene. R1 is totally dependent on facility staff for bathing. R1 uses a wheelchair for mobility and is always incontinent of bowel and bladder. On October 1, 2021 at 3:14 AM V4 (Licensed Practical Nurse/LPN) documented, "CNA (Certified Nursing Assistant) observed [R1] was trying to get out of the bed, while her roommate (R2) was standing close to her bed with a shoe in her hand. [R1] stated her roommate [R2] is beating me up with her shoe. Resident was quickly removed from her roommate. Writer completed head to toe assessment to resident. Resident has a left cheek laceration, a bruise on her nose, a red face and resident stated she also hit me on my chest..." On October 1, 2021 at 3:16 AM, V4 (LPN) documented R1 was sent to the local hospital via 911 paramedics. Hospital documentation by V5 (Emergency Room/ER Physician) dated October 1, 2021 shows: "Primary Impression: Nasal Injury. [R1] presents for evaluation from SNF [Skilled Nursing Facility] after reportedly being struck to the face by her roommate. There is no other head injury or loss of consciousness. Patient is noted to have some mild ecchymosis to the nasal bridge area but no septal hematoma. Patient is in no acute distress. X-ray does not reveal acute fracture. At this time, we will plan for discharge back to her facility." On October 5, 2021 at 1:19 PM, V4 (LPN) said, "I was finishing my med pass and I had an admission. I was called by the CNA who shouted	S9999		

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my name. When I went to the room there were two CNAs in the room, and one was holding [R1] and the other was holding [R2]. [R2] was holding a shoe in her hand and said she had hit [R1] with the shoe. I assessed [R1]. She had a laceration on her left cheek and a bruise on her nose and she also stated she was hit on her chest. I made sure she was stable and safe. I rolled [R1] to another room and I called [V2] (Director of Nursing/DON) and I called the doctor and I received an order to send both residents out to ER via 911. The police came and did a report. I felt afraid of [R2] after she hit the resident. She was agitated and screaming. [R1] cannot walk and is confined to her bed or the chair. [R1] cannot fight back. She was upset and afraid. [R1] told the police, 'I was scared to death.' The police asked [R1] what was going on and [R1] said, 'She [R2] attacked me.' [R1] said she was hit on her chest, but I couldn't see anything on her chest."

On October 5, 2021 at 1:49 PM, V6 (CNA) said, "I wasn't assigned to care for [R1] or [R2] that night. Their assigned CNA was taking care of someone else's call light. She asked me to come down while she took care of the other resident. I went down to make sure [R1] was okay because she was trying to get out of bed and she never tried to do that. When I walked in [R2] was standing with a shoe in her hand over [R1]. Then the nurse came down and [R2] was still standing with a shoe in her hand and that's when the nurse noticed [R1] was hurt. [R1] said she was afraid. [R2] has been aggressive towards others; she does have an aggressive side to her. I have seen it. [R2] was confined to her room after the incident and said, "I'll take my gun and shoot you [profanity]."

On October 6, 2021 at 12:38 PM, V7 (Nurse

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Practitioner/NP) said, "I am very familiar with [R1] and [R2]. I see them quite frequently at the facility. I was told by the facility [R2] hit [R1] with her shoe and both were sent to the hospital. [R1] is very frail and elderly. The wounds on her face were definitely caused by the shoe hitting her face."

On October 6, 2021, V7 (NP) documented regarding R1, "Patient unable to give complete, detailed or reliable history due to: Impaired memory or dementia. Was notified 10/01 that pt was struck by her roommate. A shoe was used to hit pt in the face. Pt was sent to ER, came back same day, no new orders. Her roommate was sent to hospital for psychiatric admission. Right peri-orbital area resolving ecchymosis, no redness, conjunctiva clear, stable peri-orbital edema. Left jawline-linear 'spots,' imprint of bottom of shoe? One line. Resolving. Not swollen."

The facility's Incident Report Form dated October 5, 2021 shows, "...On the night of 10/1/2021, at approximately 01:20 AM, [R1] was observed sitting at the side of her bed and [R2] was observed standing at the side of the bed with a shoe in her hand. [R1] stated that [R2] struck her. The residents were immediately separated and assessed for injury by nurse. Upon assessment, [R1] was noted to have a scratch on the left side of her face and bruise on her nose. ...After investigation, it has been determined that this incident could not have been predicted or prevented by staff. The MDS (Minimum Data Set) assessment for each resident show that there had been no aggressive behavior and that there was no significant risk of injury to those around them."

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The EMR shows R2 was admitted to the facility in May 2016. The EMR continues to show R2 was transferred to the local hospital under psychiatric petition on October 1, 2021. R2 has not returned to the facility. R2 had multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disorder), chronic kidney disease, hypertension, atrial fibrillation, vascular dementia, bipolar disorder, insomnia, major depressive disorder, and anxiety disorders.

R2's MDS dated August 11, 2021 shows R2 had moderate cognitive impairment, required extensive assistance with dressing and toilet use, limited assistance with personal hygiene and supervision with all other ADLs. R2 had adequate hearing, clear speech, and usually understood others. R2's MDS continues to show R2 had delusions, inattention, disorganized thinking, and wandering behaviors.

The EMR shows the following documentation regarding R2:

August 16, 2021 at 7:28 AM, V4 (LPN) documented: "[R2] becomes more confused, forgetful and violent for the last couple of days."

May 13, 2021 at 6:46 AM, V9 (LPN) documented: "Writer observed this resident [R2] standing over [R1] while she was sleeping, redirected [R2] back to her side of the room, writer continued passing meds went back to check on resident the door was closed, writer open the door noted [R2] standing over [R1] again resident redirected to her bed, and was asked not to close the door."

On May 5, 2021, V10 (Nurse) documented: "Resident heard screaming in her room. CNA went in and observed [R2] with her shoe in her

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hand attempting to hit [R1], stating "This is my apartment!"

On January 22, 2021, V8 (LPN) documented, "[R2] started acting out because she wants the TV off in the room, while her [R1] is watching the TV. [R2] has a problem with sharing her room at times. Redirecting and talking to resident help at times."

On January 21, 2021, V8 (LPN) documented, "[R2] TV off in her room, but [R1] is watching TV with volume low. Resident started threatening to sleep in the hallway, tried to orientate her to time, its only 6:00 PM, and thought it was 1:00 AM. Resident continued to behavior of needing a place to sleep, she then put pillows on the floor to lay down. Another staff came to help me to encourage her not to lay on floor."

On November 15, 2021, V10 (Nurse) documented: "[R2] verbally aggressive towards CNA. Cursing at her and raising her middle finger. Threatening to break the TV [R1] is watching if it is not turned off right away."

On October 5, 2021 at 10:13 AM, V8 (LPN) said, "[R2] is out at the hospital. [R2] had an aggressive episode and hit her roommate. [R2] would have outbursts and have psychotic episodes and threaten to hit somebody or get verbally aggressive. She would go in other people's rooms. She would not wear her mask. People complained she was coming in their room without a mask. Her roommate (R1) is kind and frail and could yell stop but could not defend herself."

On October 5, 2021 at 10:34 AM, R3 said, "My room used to be on the same floor as [R2]. She

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frequently came into my room and never wore her mask, and it bothered me. If I asked her to leave or said put your mask on, she would make a fist at me in the air and shake her arm at me like she would hit me. It would scare me that she would hit me. I mentioned it to the facility staff, and I was told it was none of my business. Nothing changed after I said something."

The EMR shows R3 was admitted to the facility in April 2018, and her MDS dated August 17, 2021 shows R3 is cognitively intact.

On October 6, 2021 at 9:50 AM, V12 (CNA) said, "[R2] is pleasantly confused and has her moments at times. She is hard to give care to because she gets agitated and refuses care and calls us [profanity]. There have been a couple of times when I saw her shaking her fist at people giving a gesture like she wanted to punch them."

On October 6, 2021 at 11:44 AM, V9 (LPN) said, "Back in May 2021 I had seen [R2] standing over [R1] while [R1] was sleeping. I had not seen her hit or harm the resident, but I had an uneasy feeling. I had seen her being verbally aggressive before."

On October 5, 2021 at 3:13 PM, V1 (Administrator) and V2 (DON) said R1 and R2 have been roommates dating back to April 2020. V1 said, "I was not aware there was an incident back in May 2021 where [R2] was seen holding a shoe over [R1]. It wasn't reported to me, otherwise we would have investigated it." V2 confirmed the facility has nursing progress notes dating back to November 2020 showing multiple behaviors by R2 towards R1 and said the facility has never tried to move R1 to a different room, away from R2.

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On October 6, 2021 at 11:30 AM, V1 (Administrator) said, "I was not aware of situations with [R1] and [R2]. I would assume since I didn't know about it, the family of [R1] was never told either. Had I known, we would have moved the residents to different rooms. The documentation regarding the situations would have been on the 24-hour report. I'm not sure how me or the DON missed it."

On October 6, 2021 at 11:49 AM, V13 (Power of Attorney/Family Member of R1) said, "I'm not happy about the situation with my mom (R1). They haven't given me a lot of information about the situation. I was contacted at 2:00 AM on October 1, when they sent her to the hospital. I don't want my mother back in the same room with that person. I've never complained about the care there but just too many things have been going on. My mother was a victim of battery and I said there better be a police report. I'm the one who said call the police. I have never been informed by the facility that my mom has had any other issues with this roommate. If I had ever been made aware of any other instances or problems between my mother and this roommate, I would have said separate them and keep that woman away from my mother. But I have never been told there were any other situations."

The facility's Abuse Prevention Program-Policy, reviewed 1/2019 shows: "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

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...IV. Establishing a Resident Sensitive Environment. This facility desires to prevent abuse, neglect, exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following:

Concern Identification and Follow-up: Resident and family concerns will be recorded, reviewed, addressed, and responded to using the facility's concern identification procedures. Residents and families will be informed of the facility's concern identification procedures. An essential element of "customer satisfaction" is a timely response back to the family or resident to concerns expressed. At least quarterly, the reported concerns from residents and families, and the facility response, will be reviewed by the facility Quality Management committee to assure that individual concerns are being addressed and to assess any patterns that might indicate needed changes in facility practices.

Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or misappropriation of resident property, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary.

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Pattern Assessment: At least quarterly, the Quality Management committee will review concern identification reports, accident reports, incidents reports, missing items reports, and safety committee reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, or other unusual occurrences that may constitute abuse, neglect, mistreatment or misappropriation of resident property. Based on an assessment of the reports, the Quality Management committee will further investigate and/or determine whether a change in facility practices is warranted.

V. Internal Reporting Requirements and Identification of Allegations. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer ...

Handout C: Abuse Prevention Program Training: Causes of Angry or Agitated Resident Behaviors: Signals That a Resident May Become Aggressive:
" Paranoia
" Hallucinations
" Delusions
" Change of mood
" Combativeness
" Stubbornness
" Pacing
" Restlessness
" Crying
" Suspiciousness

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