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
	IL6008098	A. BUILDING: ______ B. WING ______	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

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S 000	Initial Comments Complaint Investigation: 2117951/IL139647	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.625 k) 300.625 n) 300.1210 a) b) 300.1210 b) 300.1210 d)6) 300.3210 t) Section 300.625 Identified Offenders k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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 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:
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 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT is not met as evidenced by:

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These failures resulted in two deficient practice statements.

I. Based on observation, interview, and record review the facility failed to protect a resident from physical abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of three. This failure resulted in R1 being physically assaulted twice on 10/27/21 and sustaining injuries including a closed head injury, left wrist injury, facial laceration, and nasal fracture.
II. Based on observation, interview, and record review the facility failed to incorporate the Identified Offender Report and Recommendation into the identified offender's care plan and evaluate the effectiveness of the care plan for 1 of 1 resident (R2) reviewed for identified offenders in the sample of eleven.

The findings include:

On 10/28/21 at 8:19 AM, R1 was sitting on the bed in R1's room. R1 had a swollen nose, blood dripping from the right nare and staples under the right nare to R1's right upper lip. R1 had a red mark to the top of the right side of R1's head and bruising to the left side of the face. R1 stated, "R2 went off on me. R2 said I stole (R2) pop, and (R2) went off on me in the room (resident's room). R2 cornered me and I couldn't get out. (R2) hit me eight times in the face and head. I yelled for help and no one would come. I crawled out of my room. The maintenance guy and housekeeper were in the hall and they told R2 to stop. I came back from the hospital and R2 attacked me in the living room. R2 hit me thirteen times. No one broke it up. I had to go outside to the smoking area. A whole bunch of staff were there. I was sent to the hospital again. Getting hit hurt a lot."

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A Nurse's Note dated 10/27/21 at 7:15 AM for R1 showed, "R1 got into a physical altercation with roommate around 7:15 AM. R1 sent to ED (Emergency Department) for evaluation and treatment due to being on blood thinners. Resident moved to a different room. Resident returned at 8:20 AM with mild anxiety. As needed Ativan given; will continue to monitor."

On 10/28/21 at 11:56 AM, V13 (Housekeeping Supervisor) stated, "It happened before 7:00 AM, it was 6:50 AM and I heard punching. I heard residents yell. The maintenance supervisor and I separated them. R2 said it was over stolen money. R2 had R1 against a wall. R1 went to the ground and crawled out of the room while we kept R2 busy."

The hospital ER (Emergency Room) Patient Visit Information dated 10/27/21 for R1's first visit to the ER showed R1 was seen for a head injury and left wrist injury with instructions for ice to his wrist, a wrist splint, Tylenol for pain and to return to the ER for new or worse symptoms.

A Nurse's Note dated 10/27/21 at 10:20 AM for R1 showed, "R1 got into another physical altercation with (R1's) ex-roommate around 9:30 AM. Authorities were called. Sent R1 to the ED for evaluation and treatment due to sustaining injuries to face. R1 has a laceration to left ear as well as a bruised, swollen nose."

The hospital ER Patient Visit Information dated 10/27/21 for R1's second visit to the ER showed R1 was seen for a closed head injury, facial laceration, and nasal fracture with instructions to have the staples removed in seven days; return to the ER for vomiting, fever, swelling to the face,

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or as needed; Tylenol to be taken for pain; and to follow up with R1's provider this week.

The hospital facial bone CT (computerized tomography) dated 10/27/21 for R1 showed, "There is a comminuted nasal bone fracture. Conclusion: Comminuted fracture involving nasal bones. Fracture involving the anterior and inferior aspect of the nasal septum. Nasal septum is deviated significantly to the right. Mucosal thickening/inflammation/hemorrhage involving the middle and inferior nasal turbinates bilaterally, as well as along the course of the nasal septum. Soft tissue swelling over the upper lip, over the nasal and forehead."

A Nurse's Note dated 10/27/21 at 1:00 PM for R1 showed, "R1 returned to the facility with staples to upper lip and fractured nose. Pressure dressing applied to face/ear by ED.

On 10/28/21 at 9:03 AM, V10 (Social Service Director) stated, "I was in my office and I heard screaming. Someone was saying, "Get of me, get off me." I saw R2 and R1 in the common area. R1 was in the chair. R2 was hitting R1. We all came in there and told R2 to get off R1. When I came in that morning my assistant said R2 accused R1 of stealing his money, they got into an argument and fight. I needed to talk to R2 about it, but we had morning meeting and I went there instead. After the morning meeting I was in my office putting papers together and that is when I heard the fight out here. I was told about the first incident; the second incident I was here."

On 10/28/21 at 9:15 AM, V11 (Activity Aide) stated, "I was in here (business office) and heard R2 talking about missing money, thirty-one dollars. I heard R2 yell, so I ran out there. R2 was

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behind the couch, stood up from the wheelchair and had R1 pinned on the couch. R2 was punching R1 in the head from behind. R1 was stuck and couldn't get up. When V12 (Business Office Manager) intervened, R1 got up and ran outside. R2 stopped when V12 yelled at him to stop. R1's nose and mouth were bleeding. The CNA's (Certified Nursing Assistant) were helping R1; R1 was sent to the hospital again. R2 has had behaviors before."

On 10/28/21 at 9:26 AM, V12 (Business Office Manager) stated, "I was not here for the first altercation. When I came in, I saw R2, and R2 told me not to look at him. R2 was agitated. I told R2 that I would discuss in the meeting on how to get his money back. R2 said, "Nothing (curse word) ever gets done around here." R2 stated he had thirty-one dollars stolen from R2's wallet and went on his way. I heard yelling at the nurse's station and then R2 rolled past my office. I heard, "This is what you get for stealing." I got up from my desk and walked out. I saw R2 wailing on R1. By the time I got over there, R2 was hitting R1. I yelled at R2 to stop. I grabbed R2's shirt to get R2 to stop and R2 did. R1 ran outside into the courtyard. V8 RN (Registered Nurse) said she knew it would happen again because R2 was so agitated.

On 10/28/21 at 10:54 AM, V8 RN (Registered Nurse) stated, "I was here for the altercation. I just started medication pass when V7 RN and I heard yelling. R1 and R2's room was on C hall. R1 and R2 were roommates. Somebody yelled to call 911 because R1 and R2 had just got into a fight. I called 911 and said we needed an ambulance and cops because R1 was on blood thinners. I didn't see anything. I was told what happened. R1 was on the floor in the hallway and

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R2 was in the bedroom sitting on the bed. R1 said, "R2 just kept hitting me." When I asked R2 what happened (R2) said R1 took money and snacks or something. R1 went to the hospital. About 1.5 hours later, R1 came back with a closed head injury, bruise to (R1) head, and a swollen left wrist with a brace. R1 came to the desk and asked if R1 could sit in the living room. I said yes as long as they (R1 and R2) stayed apart. R2 came to the desk and said R1 had R2's money and was going to give it to another resident. I told R2 that he needed to talk to V1 (Administrator) because I don't have anything to do with money. R2 got loud with me and said, "If you aren't going to do something; you guys aren't going to do anything about it. R2 went over to R1 who was sitting on the couch. R2 got behind R1, stood up from R2's wheelchair and started hitting R1. V11 and V12 came out of the business office towards R1, and I called 911. V12 got R2 off R1. V13 (Housekeeping Supervisor) came into the activity area and asked R2 to go to his room. R1 was outside bleeding. We wanted to get R1 away from R2. I went outside to assess R1, and R1 was bleeding pretty bad, so I sent R1 to the hospital. R1 looked very scared and said R1 wanted to press charges. R2 gets loud, yells and instigates situations with other residents."

On 10/28/21 at 11:31 AM, V5 CNA (Certified Nursing Assistant) stated, "I came in at 6:00 AM. I didn't see the first incident. For the second one I was at the nurse's station. I heard R2 state R1 was giving out money. R2 told the nurse if she wasn't going to do anything about it then (R2) was going to. V8 RN and V7 RN were at the nurse's station. I hear yelling and saw everyone go to the activity room. I saw R2 punching R1 and R1 ran to the back door, out onto the patio. I tried to go outside but R1 had R1's foot on the door to keep

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it closed. I had to scream for R1 to open it so I could see how bad R1 was hurt. R1 was bleeding from the nose, lip and ear." V5 CNA stated R2 was on every 15-minute checks after the first fight, but she didn't find a sheet to document every 15-minute checks. There was no documentation to show R2 had every 15-minute checks being done on 10/27/21 between the first fight and the second fight.

On 10/28/21 at 1:36 PM, V7 RN stated, "When R1 came back from the hospital (after first incident) R1 had a closed head injury and a swollen wrist per EMS (Emergency Medical Services). R2 was standing behind the paramedics and I gave them a heads up. EMS told R2 to leave. V1 came out and told R2 to move, R2 got an attitude and finally did. R1 was moved to another room. When R1 came back from the hospital R1's main priority was to find R1's phone charger. R2 was lurking around and not keeping R2's distance. R2 was very intrusive and in everyone else's business. R2 came up later and heard R1 and another resident talking about money. R2 lashed out and said, "No one does anything in this place and if you don't take care of it; I am taking care of it myself." I didn't ask (R2) what (R2) meant. R2 wheeled from the front desk to the couch where R1 was sitting and started attacking R1 again. R1 ran out into the courtyard. R1 was pushing the door closed; R1 looked scared. R1 was afraid R2 was coming. R2 was punching R1, and R2 wasn't even looking at R1 but instead R2 was looking at everyone coming towards R2 as if R2 was saying it was our fault for not listening to R2. I feel we should have kept R2 and R1 completely distanced instead of letting R2 do whatever R2 wanted after the first incident happened. R2 was constantly lurking around R1 after the first fight. R2 has had

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S9999	Continued From page 8 incidents in the past of trying to get others riled up; R2 instigates things. On 10/28/21 at 2:41 PM V1 (Administrator) stated she was not at the facility for the first fight between R2 and R1. V1 stated that R2 was placed on every 15-minute checks. V1 stated staff should have filled out a form for every 15 minutes checks for R2. V1 stated she did not feel the facility could have done anything differently regarding the altercations between R1 and R2. The Nurse's Notes for R2 showed: On 10/27/21 at 7:15 AM R2 was in a physical altercation with his roommate. R2 accused R2's roommate of stealing. No injury noted. Another note with no date or time showed, "R2 made physical contact with R2's ex-roommate again, unprovoked. No injury noted." The Identified Offender Information Form done by the facility for R2 showed on 6/15/21 a name-based background check was done and on 6/24/21 a fingerprint background check was done. The name-based background check done on 6/15/21 for R2 showed a "HIT" for convictions including domestic battery/bodily harm. The Identified Offender's Criminal Analysis Security Recommendation Report dated 7/21/21 for R2 showed the following risk assessment and security recommendation for R2, "Moderate risk - The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal the need for closer observation or sustained visual monitoring on a time limited basis. Periodic assessments should ascertain whether the level of supervision	S9999		

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S9999	Continued From page 9 is sufficient." R2's Care Plan dated 8/30/21 showed, "Resident is known/has history of displaying inappropriate behavior and/or resisting care/services." R2 did not have a plan in place related to R2's history of being an identified offender with a moderate risk score. On 10/28/21 at 3:00PM V1 (Administrator) stated she follows the identified offender program, did a background check for R2 and had identified offender information for R2. The Behavior Tracking Record dated October 2021 for R2 showed the facility was tracking "Rejection of care", with 14 days of no tracking documented and no other behaviors being tracked. The MDS (Minimum Data Set) dated 9/13/21 for R2 showed R2 was alert, oriented and cognitively intact. On 10/28/21 the facility's policy for an identified offender program was requested and never received. "A"	S9999		