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
	IL6000459	A. BUILDING: ______ B. WING ______	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

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S 000	Initial Comments Complaint Investigation: 2373723/IL159515	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.3210t) 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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S9999	Continued From page 1 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. 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. 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	S9999		

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by:

Based on observation, interview, and record review, the facility failed to ensure residents were free from physical and verbal abuse. This failure resulted in R1 experiencing a corneal abrasion following physical abuse by R2. This applies to 2 of 3 residents (R1 and R2) reviewed for abuse in the sample of 8.

The findings include:

1. On May 8, 2023, at 3:37 PM, R1 was in his wheelchair in the dining room. R1 had an eyepatch over his right eye. R1 said, "[R2] punched me and hurt my eye."

R1's EMR (Electronic Medical Record) shows R1 was admitted to the facility on April 28, 2022, with multiple diagnoses including: chronic obstructive pulmonary disease, Crohn's disease, heart failure, dementia, and anxiety.

R1's MDS (Minimum Data Set) dated April 12, 2023, shows R1 has moderate cognitive impairment. The MDS continues to show R1 requires limited assistance from facility staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and walking in room.

R1's abuse care plan revised on May 12, 2022, shows, "[R1] is at risk for abuse related to: has a history of dementia."

The facility's final report to the State Agency dated May 5, 2023, shows, "On 04/29/23 at approximately 6:00 PM, the nurse witnessed both resident's (R1 and R2) arguing and had physical contact ..."

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On April 30, 2023, at 9:58 AM, V12 (Emergency Room Physician) documented, "Presenting status post being physically assaulted by another member of his nursing facility. Patient states that a gentleman came up and punched him in the face breaking his glasses yesterday, says he was also struck several times in the right shoulder. Denies any other injuries during the assault, denies fall, denies head strike loss of consciousness other than where he was punched. Primary reason for presenting today is that he has some mild pain in the right eye and says that his vision is slightly blurry. Says he had difficulty sleeping last night because the pain." The documentation continues to show R1 was diagnosed with a corneal abrasion on his right eye in the Emergency Room.

On May 9, 2023, at 2:25 PM, V7 (RN/Registered Nurse) said, "I was the nurse on April 29, 2023. I was in the dining room and I heard a commotion by the washroom, and I went over there. [R1] was in the doorway in the washroom, and the scene that I saw was [R2] hitting [R1]. [R1] was covering his face like a boxer and waving his head side to side. I saw [R2] hitting [R1]'s arms. [R2] was making contact with [R1]. It was really scary."

On May 8, 2023, at 2:13 PM, R2 said, "I have a problem with another resident, [R1]. He has yelled at me and called me an [expletive]. I had enough. I tried to talk to staff about it, but no one ever talked to me. [R1] and I got in an argument on Friday, I couldn't sleep all night because of it. The next day, [R1] was coming out of the bathroom and said, '[Expletive], you're going to jail.' So, I slapped him a few times. It hasn't gotten better since we changed rooms."

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S9999	Continued From page 4 On May 9, 2023, at 3:49 PM, V2 (DON/Director of Nursing) said physical abuse was substantiated for the incident on April 29, 2023. On May 9, 2023, at 3:18 PM, V11 (Physician) said R1's corneal abrasion happened due to the physical altercation when R2 hit R1. V11 continues to say his expectation is residents should be free from abuse. 2. R2's EMR shows R2 was admitted to the facility on February 19, 2019 with multiple diagnoses including: chronic obstructive pulmonary disease, heart failure, chronic kidney disease, depression, and dementia. R2's MDS dated May 1, 2023, shows R2 is cognitively intact. The MDS continues to show R2 requires supervision of facility staff for locomotion on and off the unit, toilet use, and eating. R2's abuse care plan revised on February 22, 2023, shows, "[R2] is at risk for abuse related to: diagnosis of dementia, major depression, history of yelling at staff, making threatening statements and history of verbal abuse from another resident." On May 9, 2023, at 3:49 PM, V2 (DON/Director of Nursing) said, "[R1] said, '[expletive] you, you are going to jail,' to [R2]. [R2] went to slap [R1] and [R1] covered his face. Verbal abuse was substantiated in this incident. There is not a separate reportable for [R1]'s verbal abuse to [R2]." On May 8, 2023, at 2:13 PM, R2 said, "I have a problem with another resident, [R1]. He has	S9999		

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yelled at me and called me an [expletive]. I had enough. I tried to talk to staff about it, but no one ever talked to me. [R1] and I got in an argument on Friday, I couldn't sleep all night because of it. The next day, [R1] was coming out of the bathroom and said, '[Expletive], you're going to jail.' So, I slapped him a few times. It hasn't gotten better since we changed rooms."

On May 9, 2023, at 2:11 PM, V13 (Psychiatric Nurse Practitioner) said, "[R1] is bullying [R2] and swearing at [R2] without provocation and [R2] gets agitated. [R2] told me yesterday, that [R1] came to [R2]'s floor and was bullying [R2]. I think [R1] is verbally aggressive and bullying [R2] and that is provoking [R2]."

On May 8, 2023, at 1:59 PM, V10 (Social Services Director) said, "I have seen [R1] stick his middle finger up at [R2], and I have seen [R1] be verbally aggressive towards [R2]."

The facility's policy titled, "Abuse Policy," dated "09/20," shows, "Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will report reasonable suspicion of a crime. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: ... 3. Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; 4. Identifying occurrences and patterns of potential

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S9999	Continued From page 6 mistreatment; 5. Immediately protecting residents involved in identifying reports of possible abuse; 6. Implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; 7. Filing accurate and timely investigative reports; This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals who have been convicted of abusing, neglecting, or mistreating individuals. Definitions: ... Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful means the individual acted deliberately, not that the individual must have intended the injury or harm ... Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment ... Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend or disability ..." (B)	S9999		