STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015192	A. BUILDING: _____ B. WING _____	07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey Facility Reported Incident of 3/13/23 and 6/25/23/IL161439 Facility Reported Incident to 6/19/23 and 6/21/23/IL161441	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4) 330.710a) 330.710b) 330.710c)1)2) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public. c) The written policies shall include, but are not limited to, the following provisions: 1) Admission, transfer, and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers. 2) Resident care services including physician services, emergency services, personal care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 services, activity services, dietary services and social services. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident was transferred using a gait belt. This applies to 1 of 2 resident (R8) reviewed for transfers in the sample of 13. The findings include: On 7/5/23 at 1:38 PM, V14 (Caregiver) transferred R8 from her wheelchair to her bed without using a gait belt. R8 had a sling on her left arm and bandages on her left elbow and right hand. On 7/6/23 at 10:05 AM, V15 (Caregiver) went into R8's room to get her out of bed. V15 transferred R8 from her bed to her wheelchair without using a gait belt. V15 propelled R8 into her bathroom and had R8 stand up and hold onto the grab bar attached to the wall, so she could remove her soiled incontinent brief. No gait belt was used. V15 asked R8 to step to the right and sit down on the toilet. R8 said she did not want to because she was scared. V15 had R8 sit back down in the wheelchair and then stand back up after a minute, holding onto the grab bar while V15 cleaned R8 and put on a clean brief. V15 had R8 sit back down in the wheelchair while she put R8's pant legs over her legs. V15 then had R8 stand back up and hold onto the grab bar while she pulled R8's pants up. No gait belt was used or offered to R8 during the observation.	S9999		

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S9999	Continued From page 2 R8's profile sheet/face sheet, provided by the facility on 7/6/23, showed she had diagnoses of vascular dementia, hypertension, fracture of upper end of right humerus, and failure to thrive. R8's Change of Condition Comprehensive Evaluation dated 6/29/23, showed she was a high risk for falls and has had two or more falls in the past year. R8's Individual Service Plan dated 6/29/23, showed R8 was at risk of falls. The service plan showed R8 needed staff assistance with transfers and toileting. On 7/6/23 at 11:57 AM, V13 (Licensed Practical Nurse) said all assisted transfers should be done using a gait belt. V13 said a gait belt should be used when transferring R8 every time. On 7/6/23 at 12:19 PM, V2 (Health and Wellness Director) said R8 cannot be transferred without a gait belt. V2 said R8 should be transferred by one staff member with a gait belt. V2 said R8 has had a decline and has had a lot of falls in the facility. The facility's Incident Reports, generated on 7/5/23, showed R8 has had 9 falls since her admission to the facility on March 28, 2023. The facility's Policy and Procedure titled Safe Resident Handling and Mobility, with a revision date of 10/2021, showed "Communication of Transfer Needs: The type of transfer method and equipment needs for each resident is indicated in the resident plan of care. The staff at any time can increase the level of transfer from what is stated in the care plan, based on the resident's ability to assist or comprehend the transfer. The staff can never reduce the level of device use..." The facility's Caregiver Training documents dated	S9999		

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S9999	Continued From page 3 5/19/23, showed the training addressed "proper transfers." The Meeting Agenda document dated 5/19/23 showed "II Safe Transfers: a. Always use your gait belt (do not lift under resident's arms, pull by arm, and/or pull clothes)" (B) Statement of Licensure Violations (2 of 4) 330.1930 Section 330.1930 Hygiene of Dietary Staff Food Service personnel shall be in good health, shall practice hygienic food handling techniques, and good personal grooming. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff wore hair nets while handling food in the kitchen. This applies to 2 of 13 residents (R8, R9) reviewed for safe food handling in the sample of 13, and 17 residents (R14-R30) in the supplemental sample. The findings include: The Resident Census by Suite document provided by the facility on 7/5/23 showed 19 residents (R8, R9, R14-R30)resided on the memory care unit on the second floor. On 7/5/23 at 11:35 AM, V32 (Memory Care Director) was in the kitchen on the second-floor memory care unit putting soup into bowls for the residents' lunch meal. V32 had long, curly hair that was over six inches below her shoulders. V32 did not have a hairnet on. V14 (Caregiver)	S9999		

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S9999	Continued From page 4 was in the kitchen placing the filled bowls onto the delivery cart. V14 had her hair pulled back with a hair tie, however, she did not have a hairnet on. Between 12:20 PM -12:35 PM, V32 and V14 plated the main course and desserts for the residents. No hairnet was worn by V32 or V14 at any time during the lunch meal service on 7/5/23. On 7/6/23 at 11:47 AM, V32 was preparing bowls of soup for that days lunch meal and carrying the bowls out to the residents in the dining room. V32 had a hairnet on that covered the top of her head, however her hair was not tucked into the bottom of the hair net at all and extended over six inches past her shoulders in the front and back. On 7/6/23 at 12:01 PM, V12 (Dining Services Director) said anyone working in the main kitchen, or in the kitchens on the units, should wear a hair net so hair or other particles do not fall into the food and contaminate the food. The facility's Personal Hygiene policy and procedure, with a revision date of 5/25/23, showed "Participants will learn what guidelines for personal hygiene are needed to promote a safe and sanitary Food and Nutrition Services department ...3. Head Covering Worn: Wear a clean hat or other hair restraint. Hair must be completely covered. Beards, mustaches, or any body hair that may be exposed (i.e., arms) must be covered." (C) Statement of Licensure Violations (3 of 4) 330.1990a) 330.1990b)	S9999		

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S9999	Continued From page 5 Section 330.1990 Food Preparation and Service a) Foods shall be prepared by appropriate methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use. b) Foods shall be attractively served at the proper temperatures and in a form to meet individual needs. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure pureed foods were reheated to at least 165 degrees Fahrenheit, failed to ensure hot foods were held on the steam table at a temperature of at least 135 degrees Fahrenheit, and failed to ensure cold foods were maintained at a temperature of 41 degrees Fahrenheit or less prior to serving. This applies to 2 of 13 residents (R8, R9) reviewed for safe food handling in the sample of 13 and 17 residents (R14-R30) in the supplemental sample. The findings include: The Resident Census by Suite document provided by the facility on 7/5/23 showed 19 residents resided on the memory care unit on the second floor (R8, R9, R14-R30). On 7/5/23 at 10:58 AM, V11 (Dietary Cook) had just finished preparing the turkey and ham salads for the lunch meal. V11 placed the salads in the	S9999		

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refrigerator located by the entrance to the kitchen. The temperature on the refrigerator registered 58 degrees Fahrenheit. V11 said it was because the dietary staff had been in and out of the refrigerator many times preparing the lunch meal. V11 said it was the same with the walk in cooler and pointed to the temperature gauge on the walk-in-cooler, which registered 47 degrees Fahrenheit. V11 grabbed the pureed foods out of a cooler located in her workstation. That cooler registered 32 degrees Fahrenheit. V11 said she made the pureed items around 6:30 AM that morning, near the start of her shift. V11 poured the mixed vegetable pureed item into a pan on the stove. V11 poured the macaroni and cheese with shrimp pureed food into another pan on the stove. At 11:06 AM, V11 started both burners under the two pans. At 11:12 PM, V11 grabbed the pan containing the pureed vegetables and started to pour the mixture into one of the bowls she had set out on the work area. This surveyor informed V11 that she would need to check the temperature with a thermometer so the surveyor could document the temperature of the food. V11 said "No, no, it's good Mama." V11 continued to pour the vegetable pureed into four bowls, and then poured the macaroni and cheese with shrimp pureed into the other four bowls, while this surveyor asked her several more times to check the temperature with a thermometer. V11 said it is good. When asked how she knows what temperature the pureed food is, V11 said when it bubbles, she knows it is between 165-178 degrees Fahrenheit. This surveyor informed V11 again that she needed to check the temperature with a thermometer so that it could be verified. V11 said she could not check the temperatures in the bowls because she could not get the thermometer in there far enough to register. This surveyor again told V11 that she needed to take

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S9999	Continued From page 7 the temperature of the food. V11 poured the bowls into two separate clean pans and turned the stove burners on again. This surveyor asked V12 (Dining Services Director) to please come out to where V11 was and assist. V12 checked the temperature of the pureed vegetables, which was 142 degrees Fahrenheit, and the macaroni and cheese with shrimp pureed, which was 140 degrees Fahrenheit. V12 said once the pureed is placed in the "hot box" that is set at 190 degrees Fahrenheit, it will get over the 165 degrees Fahrenheit. At 11:25 AM, the bowls containing the pureed foods were placed in the hot box. At 11:35 AM, V12 was asked to check the temperatures of the Italian subs that were in the walk-in-cooler. V12 obtained the temperatures of three different subs on the tray in the cooler, placing the thermometer in the middle of the subs where the cold meat was positioned. The temperatures registered 60 degrees Fahrenheit, 60 degrees Fahrenheit and 59 degrees Fahrenheit. At 11:45 AM, the temperature was checked for one of the bowls of pureed macaroni and cheese with shrimp. The temperature registered 145 degrees Fahrenheit. There were only 3 bowls of pureed food in the hot box at that time (there were eight bowls of pureed food made and placed in the hot box). V12 said he was going to put the bowls of pureed food into a pressurized machine that would heat them up fast. When asked where the other bowls of pureed food had gone, V12 was informed by staff that it had already gone up to the second-floor dementia unit. At 11:48 AM, V12 said he will definitely have some things to go over with V11 regarding reheating foods and the proper food temperatures. On 7/5/23 at 11:56 AM, V32 (Memory Care	S9999		

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Director) was in the kitchen pouring soup into bowls for the residents' lunch meal service. This surveyor asked V32 if she could please check the temperature of the soup. The temperature registered 120 degrees Fahrenheit. After obtaining the temperature, V32 continued to pour the soup into the bowls for the residents on the unit. The tray containing the Italian subs (cold meat item) were sitting on the serving line shelf of the steam table, and the chefs' salads (with ham, turkey, and hard-boiled eggs) were sitting in a tray on the counter by the steam table. V32 said after the residents finish their soup, they will start plating and serving the main course of the meal. The bowls of pureed food were sitting on the steam table. At 12:08 PM, the soup bowls had been collected from the residents and V32 went in to plate the rest of the meal. The bowls of pureed food were no longer on the steam table and the thermometer was no longer in the second-floor kitchen. V14 (Caregiver) said the pureed food was taken back down to the main kitchen to be warmed up. V14 said they must have taken the thermometer too. At 12:20 PM, V12 (Dining Services Director) brought the bowls of pureed food back up to the second-floor kitchen. V12 took the temperatures of the vegetable pureed, which registered 161 degrees Fahrenheit, the macaroni and cheese with shrimp pureed, which registered 160 degrees Fahrenheit. V12 said they made sure the temperatures were above 180 degrees Fahrenheit prior to bringing them back up. V12 also checked the temperature of the Italian sub sandwiches that were sitting on a tray on the serving line of the steam table. The Italian sub sandwiches registered 68 degrees Fahrenheit. The Chef's salad registered 68 degrees Fahrenheit, and the cucumber salad (with creamy dressing-cold food item), registered 60 degrees

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S9999	Continued From page 9 Fahrenheit. After obtaining these temperatures, the food was plated and served to the residents on the second-floor dementia unit. On 7/6/23 at 12:01 PM, V12 (Dining Services Director) said pureed foods should be reheated to 165 degrees for at least 15 seconds to kill off any bacteria that might have accumulated during the cool-down of the process. V12 said the pureed should be held at 140 degrees Fahrenheit until it is served, after reheating it to 165 degrees Fahrenheit. V12 said the soup should be held on the steam table at 140 degrees Fahrenheit because below that temperature it is susceptible to bacterial growth. V12 said cold foods such as the Italian subs should be kept at a temperature of 41 degrees Fahrenheit or less until served to prevent bacterial growth. V12 said keeping the food temperatures within the guidelines is important to prevent food-borne illness. The facility's policy and procedure titled Temperatures and Safe Food Handling, with a revision date of 9/18/18, showed "Bacteria need the following conditions to grow ...a. Danger Zone: 40 degrees Fahrenheit -140 degrees Fahrenheit ..." The policy showed "Food-Borne Illness is caused by some common factors... Failure to reheat to 165 degrees Fahrenheit or hold food at appropriate temperatures-cold food less than or equal to 41 degrees Fahrenheit, hot food greater than or equal to 140 degrees Fahrenheit." (B) Statement of Licensure Violations (4 of 4) 330.4210f) 330.4210g) 330.4240d)	S9999		

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S9999	Continued From page 10 330.4240e) Section 330.4210 General f). The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. (Section 2-103 of the Act) g). The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints. (Section 2-103 of the Act). Section 330.4240 Abuse and Neglect d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act). e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to conduct thorough investigations for allegations of theft, failed to report an allegation of theft to the state agency	S9999		

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S9999	Continued From page 11 and failed to suspend an employee following an allegation of abuse for 3 of 6 residents (R4, R5, R11) reviewed for abuse in the sample of 13. The findings include: 1. On 7/5/23 at 12:44 PM, R4's room was located at the end of the hall, near an exit door. Most of the doors on R4's floor were closed with a keyhole on the door knob and a knocker, located in the upper door. R4's door was closed. The surveyor knocked on R4's door and R4 yelled, "Come in." The surveyor asked R4 how her stay at the facility was going. R4 replied, "Terrible," dropped her head and started to cry. R4 continued to say, "I am paralyzed and need help getting up in the morning and going to bed at night. They have to use the lift to transfer me. Once I'm up, then I can move my wheelchair around here." The surveyor asked R4 if she had reported any missing items. R4 dropped her head again and stated, "I did report and all they did was say sorry and they will look into it. I don't want to talk about it again (R4's voice was becoming louder and speech was harsh)." R4 continued, "I've missing $2,000 - $3,000 worth since I move to this floor. I think I've been here about 3-4 months. First it was my rare silver coins (R4 crying with her head down). I was saving those to give to my grandchildren. I told [V1 and V2] about the missing coins and told them to call the police. The problem was that I wasn't sure the exact time the coins went missing. The last time I saw the coins was 3 weeks before I realized they were missing. I went to get them to give to my grandchildren and they were gone! Imagine that! You save these rare, valuable items to leave for your family and when you go to get them, they are gone! (R4 raising her voice and visibly upset).	S9999		

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The police came and talked to me. He said he was a sergeant. He said he had a lot of people to interview and hadn't found anything yet. Those valuable items and all they say is sorry!" R4 said the door to her apartment does lock, but stated, "Anyone (staff) can come in here. They all have keys. I lock my door and come back and it's halfway open. One day my son took me out of the facility. We locked the door and when we came back the door was wide open. I looked at him and said, "See, I told you it would be open." I've reported missing money or coins 3 times since I moved to this floor. After the coins went missing the facility told me to get a safe. So, my son (V38) got a safe and put it in the apartment for me. One day I went on an outing with my son, and I was so tired when we got home that I wanted to rest. I put $100 in my sweatpants, folded them, and put them in the bottom drawer of my dresser. I didn't think anyone would find it there. The next morning. The $100 was gone! I swear they have a camera in here watching me. They know exactly where to find my valuables and money. I'm paralyzed! Once I get in bed, I can't get out unless the staff help me. I haven't seen anyone take the money or coins, but someone had to take it. I'm so disappointed with this place. You come to a facility to rest and be taken care of, and this is how you get treated! (R4 had tears running down her cheek)." V38 (R4's son) entered the room during the conversation. V38 said he did purchase the safe for R4's room, but she had not told him that she was missing coins. R4 dropped her head and looked at V38. R4 stated, "Because I was embarrassed and didn't want to involve you in the mess." V38 said when he had taken R4 out of the facility the last time, they locked the door and when they returned R4's door was open. V38 asked R4 why she didn't put the $100 in the safe and R4 replied, "I had the

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$100 in sweatpants, in the bottom drawer of my dresser. I thought who would look in there." R4 said it takes 2 caregivers to get her into and out of bed with the mechanical lift. R4 said housekeeping comes in her room, but she's not always there when they clean. R4 said she had no idea who was entering her room when she'd find the door unlocked. R4 replied, "I expected to be able to rest here and be comfortable, but instead I found hell."

R4's Face sheet printed 7/6/23 showed diagnoses to include, but not limited to: CHF (congestive heart failure), atrial fibrillation, hypertension, history of bladder cancer and paraplegia.

R4's Health Profile printed 7/6/23 showed, R4 Mental Health Status was rated "Good," for remote, recent, and attention span. The options for documentation were "Good, Fair, or Poor." This document showed R4 required a total lift transfer and was non-ambulatory."

R4's Comprehensive Evaluation printed 7/6/23 showed R4 had no history of behaviors; required a two person physical assist or device for transfers; had no anxiety, impaired recall, or resistance of care; never had impaired judgement, disruptive behaviors, combative/aggressive behaviors, or hallucinations; was alert to surrounds; and able to understand verbal communication.

R4's Observations were reviewed from 5/1/23 - 7/5/23, these documents showed that R4 was alert and verbally responsive. There are no entries related to R4's allegations of missing coins or money. These observations showed that the facility requested a psychiatric consult on

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S9999	Continued From page 14 6/22/23 (the day after R4 reported the $100 missing). The facility's Internal Investigation Statement dated 6/5/23 showed, R4 came to V1 (Executive Director) this morning and reported 6 coins had gone missing. R4 reported last seeing coins approximately 3 weeks ago. R4 reported when she went to give them to her grandchildren on 6/4/23, they were gone. R4 requested the police be notified. The police were notified, and report was filed. The document showed, "Resident asked ED (V1) not to notify her son/POA." The facility's investigation for R4's reported incident dated 6/5/23 contained interviews from 4 caregivers (V6 and V19-21) and 1 Nurse (V34). (The staff interviewed did not include caregivers/nurses on various shifts, nor did it include housekeeping or maintenance staff. There were no other residents interviewed on R4's floor) The file included an email from V1 to the local police department and showed V1 attached the employee roster. The facility's Incident and Accident Report dated 6/19/23 showed R4 reported that she noticed $100 missing from her room yesterday evening (6/18). R4 reported her money was in the dresser, but she did not see anyone take the money. R4 decline police notification. The facility's investigation for R4's reported incident dated 6/19/23 included R4 statement. R4's statement showed, R4 reported her $100 missing from the bottom drawer of her dresser. R4 reported the money was wrapped in sweatpants. The investigation contained statements from 3 caregivers (V19-V21). (The staff interviewed did not include	S9999		

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S9999	Continued From page 15 caregivers/nurses on various shifts, nor did it include housekeeping or maintenance staff. There were no interviews of other residents residing on R4's floor.) 2. On 7/5/23 at 12:26 PM, R5's room was on the same floor as R4's. R5's door was closed. The surveyor knocked on the door. R5 answered the door, by self-ambulating with a walker. R5's apartment included a bathroom, shared bedroom, and living room area with a small kitchenette. R5 had an old desk with paperwork on it. The surveyor asked R5 if she reported missing money and cards. R5 stood up and walked over to the old desk. R5 pointed to the top, right shelf of the desk and stated, "I had $50, in larger bills, secured with a rubber band; and my cards sitting up here. They were there one day and gone the next. I have no idea what happened to them." R5 said she hasn't checked her bank or credit card records yet because she was focused on her husband's health. R5 stated, "I'm more worried about him right now." R5 said maybe she misplaced them, but they hadn't turned up yet. R5 said [V2 - DON and V3 - ADON] came to talk to talk to her about it. R5 was able to locate her bank statement from May 2023 but hadn't received the June 2023 statement yet. R5's Face sheet printed on 7/6/23 showed diagnoses to include left sphenoid wing meningioma, cataracts, high cholesterol, high blood pressure, and alcohol abuse. R5's Observations dated 5/1/23 - 6/29/23 were reviewed. There was no entry related to R5's allegation of missing cash and cards. R5's Health Profile provided on 7/6/23 showed R5	S9999		

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S9999	Continued From page 16 was ambulatory with a walker and documented as "Good" for Mental Health Status for remote, recent, and attention span. (The documentation choices were Good, Fair, or Poor). R5 had outbursts related to alcohol consumption; occasionally suffered from depression; never had anxiety; never had impaired recall - recent or distant events; never had disruptive behaviors, agitation, combative/aggression, or hallucinations; was alert to surroundings; and able to understand verbal communication. R5's Incident and Accident Report dated 6/21/23 showed, "Resident states that she was missing $50, 2 credit cards, and a debit card. She states she noticed them missing last week. She thinks that she may have misplaced them." The facility's Investigation contains interviews from V19-V21 (There were no caregivers/nurses from other shifts, housekeeping, or maintenance staff. There were no other residents interviewed during this investigation.) On 7/6/23 at 8:12 AM, V16 (RN - Registered Nurse) said she works full-time at the facility, and I have been floating between floor assignments. V16 said she was never interviewed about R4's reported missing coins or money. V16 said R4 was alert and oriented and able to make her needs known. V16 stated, "If [R4] was missing something, she would definitely tell somebody about it." V16 said she heard R5 had lost money and cards but was never interviewed about it. V16 said R5 was alert and oriented and able to make her needs known but could be forgetful at times. V16 said the resident's can lock their rooms. The nurses/caregivers and housekeepers all have keys to the resident's rooms.	S9999		

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S9999	Continued From page 17 On 7/6/23 at 10:43 AM, V21 (RA - Resident Assistant) said had worked at the facility for 1 - 1.5 years. V21 said she usually works day shift but picks up night shifts on occasion. V21 said she mainly is assigned to R4 and R5's floor. V21 said she was notified that R4 said coins and money were missing by V2 (DON - Director of Nursing) and V33 (ADON - Assistant Director of Nursing). V21 stated, "I wrote a paper that I didn't know anything." V21 said R4 can be a heavy sleeper and usually gets up around 8-8:30 AM. V21 said R4 required the assistance of 2 staff and a mechanical lift to get R4 to and from bed. V21 said R4 is alert and oriented. V21 stated, "[R5] is very alert and oriented. She gets up by herself well. She's very independent, we just check in on her. I asked [R5] if she found her money and she acted like she didn't know what I was talking about, but it did happen 2-3 weeks ago. V2 (DON) and V33 (ADON) spoke with me, and I wrote a statement that I didn't know anything. On 7/6/23 at 11:18 AM, V23 (RA) said he normally works the evening shift. V23 said he was not aware of any money, cards or coins missing. V23 said R4 only allows female caregivers to provide care to her, so he is rarely in R4's room. V23 denied being interviewed by facility staff regarding the allegations of missing money and coins. V23 stated, "I've just heard other staff talking about it." On 7/6/23 at 11:49 AM, V2 (DON) said allegations of abuse should be reported to herself, V33 (ADON), or V1 (Administrator) immediately. V2 said she completed the investigation for R4's allegation of $100 missing on 6/19/23 and completed the form. V2 said she and V33 (ADON) interviewed R4 and V19-21 (Caregivers),	S9999		

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S9999	Continued From page 18 the statements were included in the investigation file. V2 and V33 said they did not interview any other residents about missing money or valuables, nor did they interview nurses/caregivers from other shifts, housekeeping, or maintenance. V2 said R4's allegation was reported to us (V2 and V33) by a caregiver. V2 and V33 were unable to provide the name of the caregiver that reported R4's allegation. V2 said R4 was known to have money in her room and had a previous allegation of coins missing and the police were involved. V2 told the surveyor that information would need to be obtained from V1 (Administrator). V2 said V38 (R4's son) was asked to provide a safe for R4's valuables, after the coins were reported missing. V2 said the resident apartments do have a lock. The residents have their own key, but the caregivers/nurses have a master key to enter any resident room. V2 and V33 said thorough investigations are completed to ensure staff is not taking the resident's belongings. V2 and V33 said V19 or V20 (Caregivers), but they weren't sure which one reported R5's allegation of missing money and cards to them. V2 (DON) said she was not aware if R5 had located the money or cards. On 7/6/23 at 12:14 PM, V36 (Environmental Services Director) said every floor has an assigned housekeeper. V37 (housekeeper) is assigned to R4's floor, but on her days off, someone may need to float to assist with the resident needs. The housekeepers have master keys to open all the resident apartments. The resident apartments should be cleaned at least once a week and V37 should have a written schedule for R4 and R5's floor. V36 said he was not interviewed about missing cash or coins.	S9999		

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S9999	Continued From page 19 On 7/6/23 at 12:18 PM, V37 (Housekeeper) said she is the main housekeeper for R4and R5's floor. V37 said she works 3 days a week. V37 stated, "I don't have a cleaning schedule written down. I just do a cluster of rooms each day and make sure I don't do the same ones." V37 said she has a master key that opens all the resident's doors. V37 said she was not interviewed about R4's missing coins or money, or R5's missing cards or money but she heard other staff talking about it a few weeks ago. On 7/6/23 at 12:27 PM, V19 (Caregiver) said she worked at the facility for 13 years and she floats all over the building. V19 said V2 (DON) and V33 (ADON) asked her about R4's coins and money and R5's cards and money. V19 said she wrote a statement that she had not seen the coins, money or cards. On 7/6/23 at 12:38 PM, V22 (Caregiver) said she works full-time, dayshift, mainly the 2nd and 3rd floors. V22 said sometimes she picks up the evening shift. V22 said she was not interviewed about R4's missing cash or coins. V22 said she was not interviewed about R5's missing cash or cards. V22 stated, "I was off 5-6 weeks. I returned to work on 6/12/23 and that's when I heard about R4's missing coins and R5's missing money and cards" On 7/6/23 at 12:44 PM, V20 (Lead RA) said she is the lead, so she rounds throughout the facility, assists staff where needed, and reports to V2 (DON) and V33 (ADON). V20 stated, "I heard from hearsay 1-2 months ago (about R4's missing coins). [R4] did not report it directly to me. All nurses/caregivers have access to the resident's rooms." V20 said it was better to not enter the resident's apartments when the resident	S9999		

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S9999	Continued From page 20 was not present. V20 stated, "I don't know how anyone could do that to [R4]. I'm for the residents and [R4] was really upset." V20 said R4 does go out of the facility with her sister and her son at times, but lately she's been staying in the apartment. On 7/6/23 at 12:44 PM, V1 (Administrator) said any allegation of missing money, coins, or credit/debit cards should be reported to himself, V2 (DON), or V3 (ADON) right away. An investigation will be initiated. The resident and any staff that may have been in the room in the last 24 hours should be interviewed. R4 wasn't sure when the coins were taken, just that the last time she saw them was 3 weeks prior to the report. R4 did want the missing coins reported to the local police. The local police did come and speak to R4. A list of staff that had access to R4's room was emailed to the officer, but I have not heard anything more on the status of the police investigation. V1 wasunable to provide a case number for R4's police investigation. V1 said R4 had reported an allegation of 6 missing coins on 6/5/23 and an allegation of $100 missing on 6/19/23. V1 said the main caregivers for R4 were interviewed (all the interviewed staff worked day shift). V1 said most of the facility staff have access to R4's apartment. V1 said the facility did not interview any other residents, caregivers/nurses working shifts other than day shift, housekeeping, or maintenance staff. V1 replied, "What do you want me to do, interview the entire staff?" V1 said the facility did have video cameras, but none captured the view of R4's door. V1 said a thorough investigation should be completed to ensure the residents are safe.	S9999		

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S9999	Continued From page 21 3. R11's Face Sheet showed a "Move in Date" of 7/20/18. The face sheet showed diagnoses to include: dementia with behavioral disturbances, alcohol dependence with withdrawl, and hypertension. On 7/5/23 at 1:25 PM, R11 was in the activity/television room of the locked memory care unit. He was sitting in a chair sleeping with other residents watching television. R11 had no visible bruising or trauma. The facility's Incident report from 1/31/23 at 4:30 AM (emailed at 12:07 PM) showed an abuse allegation regarding R11. The incident report showed, "Possible abuse allegation, Received message from floor nurse around 8:00 AM that one of the caregivers in memory care reported that another caregiver hit a resient after the resident took his food. Employee has been suspended immediately...Head to toe assessment done, no bruising or open areas noted to skin. Resident denies any pain. Resident unable to describe if anything occured due to dementia." On 7/6/23 at 10:25 AM, V8 Licensed Practical Nurse stated she was working the night shift the evening of 1/30/23. V8 stated V9 Caregiver came to her the morning of 1/31/23 and told her V10 Caregiver had hit R11. V8 stated V9 was accusing V10 of hitting R11 after R11 had taken food from V10. V8 stated V10 denied the incident occured. V8 stated she notified V2 Health and Wellness Director (Nursing Director). V8 stated V10 was not removed from the builiding and he worked the rest of his shift. On 7/6/23 at 11:30 AM, V2 stated she was notified of the allegation of abuse via test	S9999		

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message after V10 had completed his shift of 1/31/23. V2 stated she should have been called immediatly after the incident occured and V10 should have been escorted off the facility property immediatley following the allegation. V2 stated V10 should not have been allowed to finish his shift. V2 stated the importance of suspending employees pending an abuse investigation is to protect the residents from further abuse if the allegations were true.

V10's Employee Timesheet showed he worked from 1/30/23 at 9:45 PM until 1/31/23 at 6:00 AM. (V10 worked another 1.5 hours after the alleagation.

The facilty's Abuse, Neglect, Exploitation Prevention policy (revised 10/21) showed, "Immediate measures shall be taken to ensure the safety of the resident and to prevent further abuse, neglect, exploitation. Separate the resident and the person allegedly abusing the resident."

The facility's Abuse, Neglect, Exploitation Prevention Policy (revised 10/2021) showed, "Purpose: It is the policy of [the facility] to maintain the rights of all residents to be free from abuse, neglect, exploitation, and mistreatment. The policy will provide a mechanism for prompt identification, reporting, and investigation of any allegations and/or reasonable suspicion of abuse, or complaint by a resident (or others) of abuse. Procedure: ...2. The Community will conduct a prompt investigation following complaints or allegations of abuse, neglect or misappropriation of property and will provide notification and the release of information to the proper authorities, according to state regulations and [the facility] practice guidelines ... Investigation of Alleged

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S9999	Continued From page 23 Abuse, Neglect, and Exploitation Procedures: ...2. The incident shall be thoroughly investigation and follow-up sent to the initial report withing the state allowed timeframe. All documentation shall be maintained at the Community for the state specific amount of time after the date of the report ... 14. Using the Internal Investigation Form obtain as much information as possible. Interview all staff who may have witnessed or may have knowledge of the alleged abuse. Interview the resident, or any other residents who may have knowledge of any similar actions ... Conclusion of an Allegation of Abuse Procedure: 1. The Executive Director will determine if the allegation is substantiated with the assistance of the Regional Team based on the review of the statements and investigation details ..." (B)	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015192	A. BUILDING: _____ B. WING _____	07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

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S9999	Continued From page 26	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 27	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 28	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 29	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 30	S9999		