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
	IL6005136	A. BUILDING: ______ B. WING ______	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEVILLE REHAB & HEALTH CARE	145 S CHAMBERLAIN ST, BOX 770 ROSEVILLE, IL 61473

(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 Complaint Investigation #2329226/IL166348	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 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	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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S9999	Continued From page 1 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. (Section 2-107 of the Act) These requirements are not meet as evidence by: Based on interview and record review the facility failed to protect a vulnerable resident (R1) from physical abuse that resulted in bodily harm; R1 was found to be bloodied and battered on 11/01/23. This affected one of four residents reviewed for abuse in a sample of four. Findings include: The document Abuse Prevention Program dated 11/28/16, states, "The facility reserves the right of our residents to be free from abuse. This facility prohibits 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 abuse. This is done by: conducting required pre-employment screening of employees; orienting and training employees on how to deal with stress and difficult situations; how to recognize and report occurrences of abuse immediately to supervisory personnel; training on activities that constitute abuse; establishing an environment that promotes resident sensitivity, resident security and prevention of abuse of residents; dementia management and resident abuse prevention; immediately protecting residents involved in identified reports of possible abuse; procedures for reporting of potential	S9999		

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S9999	Continued From page 2 incidents of abuse. This facility is committed to protecting our residents from abuse by any facility staff. The definition of abuse is the willful injection of injury or punishment with resulting physical harm, pain or mental anguish. Willful in this context means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm." R1's Five Day Admission Minimum Data Set (MDS), Resident Assessment and Care Screening, dated 10/26/23, Section B, Hearing, Speech and Vision, states, "Ability to Hear, Adequate; Ability to express ideas and wants, Understood; Ability to understand others, Understands - clear comprehension; Ability to see in adequate light, Adequate. Section C, Cognitive Patterns, BIMS, Brief Interview of Mental Status score of 5 out of 15 points (0-7 points = severely impaired cognition); Section D, Mood Score of 0 out of 27 points; Section E, Behavior, Behavioral Symptoms not directed toward others occurred one to three days; Section GG, Functional Abilities and Goals; R1 needed some help - partial assistance from another person to complete self-care, indoor mobility (Ambulation) and Functional Cognition; Roll left to right, Lying to sitting on side of bed, both are coded as Substantial/Maximal Assistance, (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.); Sit to Lying is coded Partial/Moderate Assistance (Helper does LESS THAN HALF the effort, Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort); Sit to Stand, Chair/bed-to-chair Transfer, Toilet Transfer, Tub/Shower transfer are coded Dependent - (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers	S9999		

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S9999	Continued From page 3 is required for the resident to complete the activity." (R1's) Care Plan for Mobility, initiated 11/04/23; Impaired Physical Mobility related to Weakness as evidenced by (R1) requires assist with Activities of Daily Living and Mobility. One staff assist with bed mobility, hygiene and dressing. (R1) transfers with two staff Stand Pivot Transfer (SPT) to wheelchair (R1) will propel self distances. (R1) feeds (himself) in Resident Dining Room (RDR) with one staff verbal cues. (R1) hollers out for Family member or Mamma. Staff redirect. (R1) is receiving therapies to increase strength, bed mobility, standing, cognition and problem solving. Care Plan for Anti-Anxiety initiated 11/04/23; (R1) uses Anti-Anxiety medications for adjustment issues and anxiety. (R1) often yells out for family member and Mamma. (R1) yells out for the police and negative statements. (R1) can be very tearful. The initial report sent to the Illinois Department of Public Health on 11/01/23 at 11:25 PM states, "Injury of Unknown Origin; 88 year old male resident with a BIMS (Brief Interview of Mental Status) score of five (5) (out of 15) (was) found to have discoloration to (the) left side of (R1's) face from unknown origin. Investigation initiated by the Administrator in Training and the Assistant Director of Nursing. The Director of Nursing (was) notified. The Power of Attorney (was) notified. Per the physician's orders, (R1) was sent to the Emergency Room for evaluation. Investigation ongoing." The five-day, final report continues, "The root cause has been determined with the assistance of the local Police Department to be physical abuse. (R1) returned to the facility with no significant injuries. The employee	S9999		

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involved was arrested on 11/03/23 and has been terminated from employment. (R1's) Power of Attorney and Physician have been notified."

V8's Witness Statement written on 11/01/23,"(V9) and I went to put (R1) back in bed. (R1) was screaming and yelling. (V9) asked (R1) if (he) wanted something to drink and (R1) said yes. I sat on the bed so (R1) quit trying to climb out. (V9) brought the juice but it didn't calm (R1) down. (V9) left to go do a shower and I put (R1's) wheelchair in front of the bed. I did try and roll R1 towards the wall and put a pillow behind him before I left the room. I went down to the resident's room that V9 was helping in the shower to get (the) bed ready. Then I helped transfer the resident into bed."

The police report, dated 11/01/23 at 10:31 PM, written by V7, Police Officer, states, "On 11/01/23, V7 spoke with (V4), Assistant Director of Nursing, in reference to a complaint of elder abuse. (V4) stated that on 11/01/23 at 8:30 PM (V4) was alerted by (V6), Registered Nurse, that (R1) had reportedly been abused. (R1) stated to (V6), that (R1) had been injured by (V8), Certified Nursing Assistant. (V4) stated the incident occurred between 7:00 PM and 8:00 PM. The suspect, (V8), has been suspended pending the completion of the internal investigation. (V7) inquired on the nature of the injuries to which (V4) stated that (R1) had a "12 to 15 centimeter" bruise on (R1's) face. (V4) stated that (R1) has dementia and a history of falling. The most recent (fall) being on 10/30/23. When asked if this could have caused the bruising observed 11/01/23, (V4) stated "no". When asked about the history of (R1), (V4) stated that (R1) has not had any altercations with residents or a history of self harm to (V4's) knowledge. At the time of this

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report, (R1) was in the process of being transported to the hospital."

The emergency room report, dated 11/01/23, states, "(R1) is a very pleasant 88-year-old male coming to the Emergency Room for facial bruising. (R1) resides at a local nursing facility. Per nursing home staff, at baseline (R1) is only oriented to (himself) and (he) is not ambulatory. (R1) has been in (his) normal state of health today. (R1) went to bed around 7:00 PM. Staff checked on (R1) around 7:45 PM and noticed left-sided facial bruising. (R1) was still in a bed. They have suspicion that (R1) (did not) fall since he cannot ambulate independently well and would have needed multiple staff members to get him off the ground. There is some concern about possible abuse. Police have already been involved. (R1) cannot give any history secondary to (his) underlying dementia. Staff reports (R1) is currently at baseline. Upon arrival, (R1) seems to be in good spirits, making jokes. (R1) has some tenderness to the neck, but otherwise denying pain everywhere else. No other complaints. On Eliquis. CT reports showing no evidence of acute traumatic injuries. Incidental finding of possible normal pressure hydrocephalus. Clinical Impression: 1. Contusion of face, initial encounter 2. Cerebral ventriculomegaly. (R1) Discharged."

On 11/04/23 at 12:06 PM, (R1) stated, "I was at a different (facility) the other night and "he" tried to kill me. I'm glad I'm here now as (the staff) are nice to me." When asked what happened (R1) was unable to reply. (R1) again stated, "He tried to kill me, but I fought him off."

On 11/05/23 at 12:12 PM, V9, Certified Nursing Assistant, stated (during a phone interview), "(R1)

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was in (his) bed in his room yelling, which (R1) does frequently in the evenings. When I went into (his) room, (R1) had his feet off of the bed. I tried to put them back under the sheets but (R1) was agitated and pushed my hand away. I went out to the nurses' desk and asked (V8, V10), Certified Nursing Assistants, if one of them could help me with (R1). We were walking back to (R1's) room and (V8) stated, 'I just want to pop (R1) in the mouth.' When we got to (R1's) room (R1) was yelling and (V8) yelled at (R1) and told him to 'Shut up. You (R1) wanted to get into bed and now you're going to stay there.' I was really surprised to hear (V8) raise her voice to (R1). We got (R1) situated in (his) bed and covered up. I needed to help another resident take a shower and told (V8) that I was going to go do that. (V8) was picking up (R1's) room and I thought (she) would also be leaving the room after me. I gave the other resident a shower and put her into her bed. It took about 15 to 20 minutes. When I was walking back to the nurses' station, (V10), Certified Nursing Assistant, asked me to come into (R1's) room. (V6), Registered Nurse was also in the room attempting to give (R1) (his) medications. (V6) asked me if (R1) had fallen. I told her that I was with (R1) just 15 to 20 minutes ago and (he) was fine at that time. I had not been aware that (R1) had fallen during that time. I noticed that there was blood on (R1's) pillowcase and bed sheets and that (R1's) lip was purple and swollen with a cut that was bleeding on the side of his mouth. (R1) had a red handprint on the left side of (his) face going up to (his) temple. (R1) was yelling, 'He's going to kill me, I had to fight him.' (V8) came into the room and then (R1) pointed at (V8) and said, 'He hit me!' (V8) just laughed it off and left the room."

On 11/05/23 at 12:31, V10, Certified Nursing

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S9999	Continued From page 7 Assistant, stated (during a phone interview), "I had been in another resident's room and was returning to the nurses' desk when I walked past (R1's) room and heard (R1) yelling. (V6), Registered Nurse, met me and asked me to help her give (R1) (his) medications. When we went into (R1's) room we noticed the blood on (R1's) sheets and pillow. I turned on the overhead light and that's when I saw blood, some dried and his swollen busted lip and a red handprint on (R1's) face. (R1) shouted, 'Why does he want to kill me?' (V6) and I were trying to figure out what happened to (R1). If (R1) had fallen out of bed (he) would have needed two of us to get (R1) back into bed and with a mechanical lift. That's when we saw (V9), Certified Nursing Assistant, walking by the room. We asked (V9) to come in and if (R1) had fallen out of bed. (V9) said that (R1) had not fallen that (she) was aware of and was shocked to see (R1's) face and the blood on the bed. (V8), Certified Nursing Assistant, walked into the room and (R1) pointed at (V8) and said, 'That's who tried to kill me, don't let him get away.' (V8) chuckled and left the room. Things just seemed off; we couldn't think of any explanation of how (R1) was hurt except that (V8) had done something." On 11/05/23 at 12:43 PM, V6, Registered Nurse, stated, (during a phone interview), "I went in to give (R1) (his) medications at 6:30 PM or so. (R1) wasn't interested in taking them at that time so I decided to wait a bit. (R1) was fine at that time. I took a lunch break and came back in a half of an hour. I asked (V10), Certified Nursing Assistant, to help me give (R1) his medications. When we went into (R1's) room we were surprised to see that (R1's) mouth was swollen and bleeding and that he had a red mark on (his) face. (R1) was yelling, 'Call the police, he's going	S9999		

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to kill me.' We helped (R1) sit up in bed and saw the blood on the sheets and pillowcase. (V10) saw (V9), Certified Nursing Assistant, walking by the room and asked her to come in. We asked her if (R1) had fallen out of bed and (V9) didn't know of any fall. (V9) told us she was in (R1's) room 15 or so minutes prior with another staff, V8, Certified Nursing Assistant, and (R1) had been fine when she left him with (V8). V9 said she'd gone to give another resident a shower and help her to bed. When (V9) saw (R1's) face she had no idea what had happened. (V8), Certified Nursing Assistant, walked into the room. (R1) became agitated and yelled, 'There he is!' Once (V8) left (R1) became calmer and we were able to change him and get (R1) into a wheelchair. I took (R1) to the nurses' station and gave him his medications and he continued to calm down. I called the ADON and Administrator and let them know that there had been an incident. They told me to keep (R1) at the nurses' station and that all the employees were to stay at the facility until they were able to get there."

On 11/06/23 at 10:10 AM, V3, Director of Nursing, stated, "I knew (V8), Certified Nursing Assistant, as I had worked with (V8) at our sister facility. (V8) has always been very pleasant and good with the residents. (V8) has had a troubled family history. (Her) husband committed suicide a few years ago and (V8's) son committed suicide about a year ago. I reached out to V8 by phone and text after this incident. (V8) told me that (she) wasn't feeling well and couldn't see - everything was blurry. (V8) also indicated that (she) was contemplating suicide. When asked (V8) did not explain what happened with (R1) on 11/01/23 but kept saying that (she) was innocent. I was concerned about (V8's) mental state and notified the police requesting that a 'well check'

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be sent to (V8's) home. The next day I received a call from (V8) saying that she had spent the night at the hospital and was feeling better. (V8) said that the hospital was going to discharge (her), and she would then come into our facility to talk with us. The police came to the facility prior to (V8) arriving here. (V8) was arrested in the parking lot before (she) came into the facility. We do have (V8's) Witness Statement from the evening the incident occurred, but we never talked to (V8), so we do not know what she is saying about the incident."

On 11/06/23 at 12:30 PM, V4, Assistant Director of Nursing, stated, "I was called at 8:15 PM on 11/01/23 and informed about the incident with (R1). I asked everyone to stay at the nursing home that was involved and that (V8) stay at the nurses' station and not be with residents. I arrived at 9:00 PM and began an investigation. (R1) had been taken to the nursing station on the other side of the building. (V6), Registered Nurse, and I took (R1) to (his) room and did a head-to-toe physical assessment. There were no new marks on (R1's) arms. (R1) had a split lip and also a red mark on (his) left cheek in the form of fingers/hand that reached up to (his) temple. After the assessment, (R1) grabbed my hand and kissed it and told me, 'Someone wants to kill me, don't let them.' (V1), Administrator arrived at 10:00 PM. I notified the police, (R1's) doctor and (R1's) Power of Attorney. (V7), Police Officer, arrived about a half hour after I called. I gave him the details of the incident. (V7) also interviewed (V6), Registered Nurse, and (V8, V9, V10), Certified Nursing Assistants. (R1) had been sent to the hospital for assessment. (R1) is on a blood thinner and we wanted to make sure that (he) was okay. The hospital took X-Rays and returned (R1) to the facility."

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S9999	Continued From page 10 On 11/07/23 at 10:55 AM, V8, Certified Nursing Assistant., stated, (during a phone interview), "I was at the nurses' station on the evening of 11/01/23. (V9), Certified Nursing Assistant came out and asked me to come help with (R1). (R1) was making a lot of noise and trying to get out of bed. We tried to calm (R1) down, asking (R1) if (he) would like something to eat or drink and (V9) got (R1) some juice. Then (V9) said she would see if (V6), Registered Nurse, could give (R1) (his) evening medications to help calm (R1) down. (V9) said (V6) was on (her) lunch break and that (V9) needed to help another resident take a shower. (R1) continued to scream out, it bothers other residents. I was trying to quiet (R1) down and put my hand a few inches over (R1's) face without touching (him) to get (R1's) attention. I told (R1) to be quiet but it didn't help. I rolled (him) toward the wall (the other side of the bed is against the wall) and put a pillow underneath him toward the outside of the bed so (R1) couldn't roll out of bed. I also put (R1's) wheelchair against the bed in case (he) did get up. It was 7:30 and I needed to take the residents outside that smoke, so I left the room. (R1) was fine when I left (R1), just yelling for (his) wife. When I came back onto the hall later, I opened the shower door and asked (V9) if (she) needed help with the resident she was giving a shower to. I got the mechanical lift and took it to that resident's room and helped (V9) get that resident into bed. Then I took the mechanical lift and continued to help residents get into bed that wanted to. Then I walked down the hall and saw (V6), Registered Nurse, (V9 and V10), Certified Nursing Assistants, in (R1's) room. I stood at the doorway. (R1) pointed at me and said, 'Get out of here, He's trying to kill me!' I just kinda laughed it off and left to help other residents. I don't know what was going on."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005136	A. BUILDING: ______ B. WING ______	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEVILLE REHAB & HEALTH CARE	145 S CHAMBERLAIN ST, BOX 770 ROSEVILLE, IL 61473

(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 11 (B)	S9999		