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
	IL6015192	A. BUILDING: ____ B. WING ____	C 10/30/2023

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 Facility Reported Incident of 10/8/23/IL165970	S 000		
S9999	Final Observations Statement of Licensure Violations 330.4240a) Section 330.4240 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) (A, B) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure one of four residents (R1) was free from abuse in the sample of four reviewed for abuse. The findings include: R1's Face Sheet dated October 26, 2023, shows R1 was admitted to the facility on March 8, 2023 with diagnoses including diabetes, anemia, dementia, and alzheimer's disease. R1's Care Plan dated October 18, 2023 shows, "(R1) has been exhibiting exit seeking behavior and latching on to residents. Psychosocial interventions to be put in place: 1:1 group program, participate in a cooking club. Psych consult ordered. Resident has a 1:1 caregiver until a bed is available at the behavior health center."	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 R1's Health Progress Notes dated October 8, 2023 at 12:45 PM shows, "An incident has been recorded. In the hallway before elevator, noticed resident was holding another resident's hand and verbalized will help the resident with the bathroom. The other resident keep [sic] saying I will fall. (R1) did not want to let go of the other resident's hand. (R1) continued walking when the nurse on duty witnessed a RA (resident attendant) (V9) RA running towards the residents. (V9) attempted to separate the residents when (R1) punched (V9) into her face and left upper lip. In return, (V9) pushed (R1) against her chest and (R1) fell onto the floor. (R1) hit her middle back against the corner on the apartment door and landed on her bottom." R1's Progress Note dated October 8, 2023 at 7:53 PM shows R1 had skin discoloration noted to her left back that measured 2 centimeters by 4 centimeters. The facility's Incident and Accident Report in regards to the incident that occurred between R1 and V9 shows, "After the investigation was complete, it was founded that the staff member pushed the resident. Police authorities were notified. Staff member has been terminated." The facility's Potentially Compensable Event form dated October 11, 2023, shows, "Resident (R1) was grabbing on to another resident. (V9 RA) came up to residents yelling at them. (R1) swung a purse at (V9) and (V9) proceeded to push (R1) to the floor." On October 26, 2023 at 1:31 PM, V1 Administrator/Abuse Coordinator said, he was notified by V3 Director of Nursing of the incident	S9999		

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S9999	Continued From page 2 that occurred with V9 and R1. V1 said he reviewed the facility's camera footage and it showed R1 waving her purse around and heard V9 yelling. V9 went into the middle of R1 and the other resident when V9 pushed R1 and R1 fell onto her buttocks. The facility's Abuse, Neglect, Exploitation Prevention policy revised October 2021 shows, "It is the policy of [Nursing home] to maintain the rights of all residents to be free from abuse, neglect, exploitation, and mistreatment." (B)	S9999		