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
	IL6015648	A. BUILDING: ______ B. WING ______	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SNR LVG OF HAZEL CREST	3701 WEST 183RD STREET HAZEL CREST, IL 60429

(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: 2393648/IL159389 - No Deficiency 2394318/IL160255 - No Deficiency 2394399/IL160320 - No Deficiency Facility Reported Incident Investigations: FRI OF 6/30/2023/ IL162505 - No Deficiency FRI OF 7/4/2023/IL162515- 330.4240 f) FRI OF 8/1/2023/IL162791 - No Deficiency FRI OF 8/15/2023/IL163781- 330.4240 f) FRI OF 9/1/2023/IL164463 - No Deficiency FRI OF 9/4/2023/IL164524 - 330.4240 f) FRI OF 11/10/2023/IL166930 - No Deficiency FRI OF 7/28/2023/IL162787 - No Deficiency FRI OF 6/22/2023/IL162209 - No Deficiency FRI OF 6/10/2023/IL160952 - No Deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.4240f) Section 330.4240 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. This requirement was NOT MET as evidenced by:	S9999		

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	S9999		

Continued From page 1

Based on interview and record review, the facility failed to keep residents (R7, R10, R11) free from abuse reviewed for abuse in the sample of 13 residents.

Findings include:

R6's diagnosis include: Dementia, R7's diagnosis include: Vascular Dementia with behavioral issues, Depression, Anxiety, Agitation, Hyperkalemia. R10's diagnosis include: Dementia and Anxiety. R11's diagnosis include: Dementia.

On 2/3/24 at 9:53 am V1 (Executive Director) stated, R6 and R7 were sitting in the dining room at the same table. V1 stated, R6 had behaviors, she used to lash out and cursing at staff. V1 stated, with this incident R6 took a plate of food and threw it towards R7's head. V1 said, staff immediately separated both residents. R6 was sent out for observation and when R6 came back she was originally in the garden unit and R6 was placed in country, away from R7. V1 stated, R6 was not with the facility long, they were sitting at the same table when the incident occurred. V1 stated, R6 needed to be separated from R7 that was the conclusion of the investigation. V1 stated, prior to this incident, R6 had never lashed out at another resident, in country unit. V1 stated, R6 started to decline and was transferred to skilled nursing.

R6's (07/04/2023 at 1:39 pm) progress note documents in part: An incident has been recorded. Incident Type: Aggressive Act Incident Summary: During lunch time, on 07/04/2023, Resident was involved in a violent altercation with another resident. Nurse was notified by the victims (R7's) daughter, who witnessed the

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S9999	Continued From page 2	S9999		

incident occur. R6 picked up a residents lunch tray, and threw it towards the victim (R7), which caused the plate to hit the victim in the head, and food to fall on the residents (R7's) clothes. Resident has also been combative towards staff during bed to chair transfer. Resident is currently being sent out via ambulance for a psych {sic} Evaluation. VS (vital signs): BP (blood pressure) 135/80, P (pulse) 98, Temp (temperature) 97.4. Incident Location: Dining Room Day & Time of Incident: 07/04/2023 1:00 PM.

R7's (07/04/2023 at 2:09 pm) progress note documents in part: Resident was involved in a violent altercation with another resident today during lunch time. a resident threw a plate of food at R7's head, while her daughter was at the facility visiting. Although R7 has complaints of pain on the front of her forehead, her daughter did not wish to have her sent out to the hospital. There is no bruises, knots, or broken skin observed. Resident was given an icepack to place on her head. will continue to monitor for s/s (signs and symptoms) of distress.

On 2/3/24 at 10:09 am V1 stated, on 8/15/23 R10 was attempting to go to R11's room and R10 was telling her you can't come in and they had an altercation. R10 was with the walker and tried to push her way into R11's room, but R11 pushed R10's walker not to come in. V1 stated, the nurse was called to the unit, it was reported R11 was observed hitting and scratching another resident, R10 was attempting to enter R11's room, R10 was the aggressor and hit R11 first than they started to hit each other.

On 2/6/24 at 10:39 am V20 (Licensed Practical Nurse) stated, she was the nurse on duty for R10 and R11 incident. V20 stated, on 8/15/23 R10

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S9999	Continued From page 3	S9999		

went to R11's room and a fight happened. V20 stated, R10 was scratched and R11 was hit, however staff were able to go there and calm them down and redirect them.

Facility's reportable incident to state agency regarding R11 documents in part: 8/15/23 at 4:28 pm, V1 called to unit per staff member. Staff member stated R11 was observed hitting another resident. Staff states the other resident (R10) was attempting to enter residents room.

R11 (08/15/2023 at 8:53 pm) progress note documents in part: An incident has been recorded. Incident Type: Behavioral (Illinois) Incident Summary: Writer called to unit per staff member. Staff member states that resident was observed hitting another resident. Staff states that other resident was attempting to enter residents room and when resident stopped her resident hit her and fight ensued. Writer asked resident what happened and resident was unable to recall events. Scratch noted to right side of face, no other injuries noted. POA (power of attorney) made aware and does not want resident sent out. Nurse practitioner made aware of events orders given for resident to see in house Psych {sic} MD (physician). Orders noted and carried out. Resident currently sitting in dining area for dinner calm demeanor noted. Will continue to monitor closely. Incident Location: Hallway Day & Time of Incident: 08/15/2023 4:28 PM.

Facility's abuse policy (12/18) documents in part: Its is the policy of the facility to maintain the rights of all residents to be free from abuse.

(B)