

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
---	---

(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 S 000
Complaint investigation:
1999050 /IL118226

S9999 Final Observations S9999
Statement of Licensure Violations
300.1210b)
300.1210d)6)
300.3240a)

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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/13/20
--	-------	---------------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
---	---

(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	<p>Continued From page 1</p> <p>and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidence by:</p> <p>Based on observations, interviews and record reviews, the facility failed to prevent a resident (R1) from being injured by another resident with a history of battery and assault. This failure resulted in one (R1) of three residents reviewed for abuse receiving four sutures on her upper lip and multiple bruises to her face.</p> <p>Findings include:</p> <p>R1 is a 69 year old. Diagnosis include Major Depression, Anxiety, and Age Related Physical Debility. Per MDS(Minimum Data Sheet) dated 11/27/19, R1's cognitive assessment score was 10, indicating she is mildly cognitively impaired.</p> <p>On 12/24/19 at 9:40AM V1, Administrator, said she investigated the incident on 12/9/19 and watched the facility surveillance footage. V1 said no one had entered or left R1's room except for R2. V1 said after investigating there was no other conclusion except that R1 and R2 had an altercation. V1 said R1 verbalized once that R2 attacked her but would not say more and neither resident would say what happened. V1 said the incident happened in the morning. R1 and R2 were roommates on 12/9/19.</p> <p>On 12/24/19 at 10:18AM R1 observed by</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
---	---

(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 2	S9999		
	<p>surveyor with a light purple crescent shaped bruise under left eye along her cheek bone. On the right side of her nose, maxillary region, is a light purple discoloration. R1 has a dry scab over her left upper lip. R1 said "someone hit me, I don't know who." R1 changed the subject and would not discuss the bruises or altercation further.</p>			
	<p>On 12/24/19 at 10:36AM V3, Nurse, said she was assigned to R1 and R2 on 12/9/19. V3 said she was alerted by the Certified Nursing Assistant (CNA) that something had happened to R1. V3 stated she did not know the CNA's name. CNA later identified as V4. When she(V3) entered the room, R1 was sitting on her bed holding her face. R1 had a nose bleed and was getting anxious. V3 said no one saw what happened. V3 said she provided first aid and applied ice to R1's nose and the back of her neck.</p>			
	<p>On 12/24/19 at 10:42AM, R4(friend of R1) said she saw R1 after the incident on 12/9/19 occurred and her face was all black and blue.</p>			
	<p>On 12/24/19 at 11:00AM V4, CNA, said on 12/9/19 she saw R2 walking nervously in the hall and she kept looking back at her room and rubbing her hands. V4 then saw R1 wobbling out of her room and holding her face. V4 said R1's face was covered in blood.</p>			
	<p>On 12/24/19 at 11:10AM V5, Quality Assurance Nurse, said R1 and R2 were both seen in their room and in their beds unharmed around 7:30 or 8:00AM on 12/09/19. V5 said she didn't see any altercation between R1 and R2, but V4 called for her to assist R1. V5 said when she entered R1's room V3 was providing care to R1 who was bleeding. V5 said R1 is forgetful and has</p>			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
---	---

(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 3 S9999

memory problems. R2 had a history of talking to herself, acting paranoid, delusional, and being agitated.

On 12/24/19 at 11:39AM V7, Psychiatric Rehabilitation Services Coordinator, said R2 was brought into her office on 12/9/19 and was reminded of the facility rules and she remained with her until the ambulance arrived for her. V7 said she saw R2's hands and the right hand was a different color than the left and she had a dry scratch above the fourth finger knuckle. V7 said that R2's right hand was discolored. It was an "absolutely different" shade of pink compared to the left hand and as time passed the color returned to her usual color. V7 said R2 did not say what happened to R1 but said no one else had entered the room.

On 12/24/19 at 12:00PM V8, Former Psychiatric Rehabilitation Services Director, said she didn't see the altercation but spoke with R1 and R2. R1 denied falling.

On 12/26/19 at 9:00AM V10, CNA, said on 12/9/19 she was in the break-room when V4 notified her that R2 attacked R1. V10 said after she was notified she assisted R1 by cleaning the blood off her face and changing the bloody bed sheets.

On 12/26/19 at 10:15AM V1 said R2 was alert and oriented and able to make her own decisions.

On 12/26/19 at 12:00PM V13, Nurse Practitioner, said she saw R1 after the incident occurred. V13 said R1 would not say what happened, despite multiple times asked, with and without family and or staff present. R1 had multiple purple bruises including on her chin, jaw line, right eye area, and

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
--	---

(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 4 S9999

on her neck. V13 said R1 denied falling. V13 said she has seen bruising on people who have fallen out of bed and this did not look like that. V13 said "an occurrence occurred but we don't know what may have caused R1's bruising.

On 12/26/19 at 12:35PM V14, Police Officer, said he was called to the facility for a report of a bloody nose. V14 said when he saw R1 she looked like she had been attacked. She had said her roommate attacked her but she could not identify who that was, and then said she could not remember anything. V14 said R2 had no blood on her hands but her hands were swollen. V14 said R2 had done something to cause R1's injury. V14 said R2 had an extensive criminal history, but he was unable to arrest her because R1 was unable to identify who hit her.

R1's After Visit Summary from the hospital dated 12/9/19 denotes reason for visit: assault victim; diagnosis denoted injury of head and lip laceration; and instructions include "you received four sutures to your upper lip."

Accident Report written by V3 dated 12/9/19 denote writer was called to R1's room and observed R1 sitting on the bed with swelling and bruising on her face. Contributing factors denoted aggression of co peer / roommate.

R1's Care Plan includes a focus dated 12/10/19 for bruising to the "entire facial area, secondary to injuries." Four sutures in inner upper lip. On the same page of the Care Plan a focus dated 12/11/19 denotes "resident has been a victim of suspected abuse."

On 12/10/19 a Progress Note written by V5 denotes R1 is still observed with swelling and

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
---	---

(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 5	S9999		
	bruising to right and left side of face. A Progress Note written by V3 on 12/10/19 denotes R1 has many facial bruises.			
	R2 is 44 years old and diagnosis include Major Depressive Disorder, Anxiety, and Bipolar Disorder.			
	R2's Criminal History Record issued by the State Police dated 8/7/19 denotes charges including Battery and Assault in 2015, Battery in 2014, 2013, and 2003.			
	On 9/6/19 the facility received a Criminal History Analysis Report for R2. The report denotes R2 as a moderate risk. The resident requires closer supervision and more frequent observations than standard or routine for more residents in an open facility. The specific considerations important in the recommendations include "threatened her roommate."			
	On 9/19/19 R2's cognitive assessment score was 15, indicating she is cognitively intact.			
	The facility's Final Incident Investigation Report dated 12/13/19 denoted R2 had displayed socially inappropriate aggressive behavior towards R1 in their bedroom at approximately 9:45AM. First aid was applied and 911 was called. R1 was taken to the hospital for treatment to her injuries.			
	The facility policy for Abuse Prevention dated 12/2019 denotes Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention.			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY NURSING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
---	---

(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 6	S9999		
	(B)			