

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/30/2018
NAME OF PROVIDER OR SUPPLIER ALDEN TERRACE OF MCHENRY REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 803 ROYAL DRIVE MCHENRY, IL 60050		
(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 investigation to incident of July 22, 2018/IL 104568	S 000			
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/16/18

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALDEN TERRACE OF MCHENRY REHAB

**803 ROYAL DRIVE
MCHENRY, IL 60050**

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S9999	Continued From page 2 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 and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to supervise a resident with known history of aggressive behavior towards others. This resulted in R1 assaulting R2. R2 sustained a fracture on her right 5th finger and a laceration on her left eyebrow that required sutures. This applies to 2 of 3 residents (R1, R2) reviewed for safety and supervision in the sample of 5. The findings include: R1's Physician Order Sheet dated July 2018 shows R1 has diagnoses that include Vascular Dementia with Behavioral Disturbances and Mood Disorder due to known Physiological Condition. R1's Minimum Data Set Assessment dated July 13, 2018 shows R1's cognition is severely impaired. The same MDS shows R1's behavioral symptoms towards others (hitting, kicking, grabbing, and abusing others) is exhibited every 1-3 days.	S9999		

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S9999	Continued From page 3 The facility's final incident report dated July 28, 2018 showed that on July 22, 2018, R1 grabbed R2 by the hair and R2 landed on the floor. R2 sustained a laceration to R2's left eyebrow and 4th and 5th digit fracture to R2's right hand. R2 was sent to the hospital and received sutures on the laceration of R2's left eyebrow. R2 was also sent to an Orthopedic clinic and confirmed R2 has a fracture on the 5th finger of R2's right hand. R1's progress notes dated July 28, 2018 shows R1 was readmitted to the facility on July 28, 2018 after being readmitted to a behavioral hospital unit due to the incident mentioned above. On July 30, 2018 at 9:00 AM, R1 was pacing from the dining room to the hallway aimlessly. R1 would sit in the family room then move to the dining room back and forth. At 10: 30 AM during group activity R1 sat down for a short time then went to sit in the family room then returned to the activity. On July 30, 2018 at 8:55 AM, V5 (Dementia Unit Manager) said that on July 22, 2018, V5 was informed of R1 being combative. V5 said R1 pulled R2 down to the floor. R2 injured R2's right 5th finger and lacerated R2's left eyebrow. V5 said R1 had exhibited aggressive behavior on the evening shift in the past. R1 needs to be monitored closely. V5 said when R1 started to get aggressive, staff should have stayed with R1, providing 1:1 monitoring. V5 said that could have prevented R1 from hurting R2. On July 30, 2018 at 9:00 AM, V4- Certified Nursing Assistant (CNA) said that on July 22, 2018, R1 was very agitated. V4 said R1 was pacing back and forth and was attempting to exit	S9999			

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S9999	Continued From page 4 the back door. At dinner time around 6-6:30 PM, R1 kept on going to the medication cart, got the ice water pitcher then slammed it down. Water spilled over the floor. R1 took the bottle of supplement and poured to the floor. V4 said R1 took V4's hand and bent it back. V4 said V4 tried to pacify R1 but R1 proceeded to attempt to get out from the back door. Then R1 came back and sat on the couch in the family room. V4 said V4 then went to the dining room and left R1, by R1's self in the family room. V4 also said V4 had to toilet another resident. V4 said then V4 heard screaming. V4 went back to the family room and saw R2, already on the floor bleeding. V4 said R1 has a history of aggressive behaviors. R1 had thrown a chair at a staff last month. R1 had hit staff and attempted to open exit doors. V4 said staff have difficulty redirecting R1 when R1 becomes agitated. V4 said on July 22 2018 when the incident happened, there was no one watching R1 at all times. Staff were busy feeding and helping other residents with toileting and laying down residents to bed. On July 30, 2018 at 10:11 AM, V6 CNA said that on July 22, 2018, R1 was very angry and agitated at the start of the evening shift-3:00 PM. At around dinner time, (6:00 PM) R1 continued to be agitated, R1 was grabbing things on top of the med cart. No one was with R1 when the CNAs were with other residents. V6 said V6 was in another resident's room putting the resident to bed when V6 heard screams coming from the family room. V6 said V6 looked and R2 was on the floor. On July 30, 2018 at 12:54 PM, V3 (Registered Nurse) said V3 was the nurse on July 22, 2018. V3 said R1 was very anxious and aggressive. R1 was attempting to open V3's med cart. R1 was	S9999			

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S9999	Continued From page 5 pacing back and forth to the medication cart. R1 took the water pitcher and the pill crusher from the med cart. V3 said V3 tried to redirect R1. V3 said V3 tried to give R1, R1's medication but R1 refused. R1 then went to the family room and sat on the sofa. V3 said V3 was inside the dining room passing medication and occasionally would look out to the family room as V3 was passing V3's meds. When V3 went back to the family room, V3 saw R1 pull R2's hair and R2 landed on the floor. R2 was bleeding. V3 said R2 was sent to the hospital. V3 said a staff should have stayed with R1 when R1 was in the family room. That would have prevented R1 from harming R2. R1's progress notes dated June 3, 2018 at 3:56 PM, June 1, 2018 at 3:26 PM and May 30, 2018 at 5:20 PM, (all evening shift) shows R1 had physical aggressiveness towards others. R1's careplan dated April 16, 2018, show "When R1 become physically aggressive, 1.remove R1 of area of trigger. 2. Inform resident of his body language and physical aggressive towards others. 3. Ask resident to assist staff with project to redirect from behavior." R1's careplan had no revisions following the occurrences listed above. The facility policy on Behavioral Emergencies dated October 2015 shows, each resident will be provided with a safe place of residence. The facility did not provide policies for Dementia Care and Behaviors at the time of this investigation. (B)	S9999			