

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/11/2022
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NAME OF PROVIDER OR SUPPLIER DECATUR REHAB & HEALTH CARE CT	STREET ADDRESS, CITY, STATE, ZIP CODE 136 SOUTH DIPPER LANE DECATUR, IL 62522
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S 000	Initial Comments Complaint Investigation: 2263523//IL146595 Investigation of Facility Reported Incident of April 11, 2022//IL146223	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3210t) 300.3240f) 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. 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	S9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>and assistance to prevent accidents.</p> <p>Section 300.3210 General</p> <p>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>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. (Section 3-612 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure R2 was not subjected to physical and verbal abuse by another resident, R1. R1 and R2 are two of four residents reviewed for abuse in the sample list of 10. This failure resulted in R2 expressing fear and trauma related to physical and verbal altercations with R1. R2 has expressed fear of coming into contact with R1 and this limits R2's movement about the facility, including not leaving R2's bedroom and not participating in dining activities where R1 is present.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Findings include:</p> <p>The facility's Final Report dated 4/18/22 documents on 4/11/22, R1 and R2 were involved in a physical altercation. This report documents R1 recently admitted to the facility on 4/9/22 and is alert and oriented. R2 was admitted to the facility 9/20/17 and is alert and oriented. This report documents R2 reported to V5, Licensed Practical Nurse (LPN) that R1, R2's roommate bit R2 after R2 went to R1's side of the room to talk to R1 because R1 was throwing things at R2's television. This report documents R1 stated R1 bit R2 because R2 attacked and jumped on R1. R1 stated R1 was lying in R1's bed when R2 jumped on R1 and R2 attempted to cover R1's nose and mouth. R1 stated R1 bit R2 in self-defense. This report documents "several alert and oriented residents were interviewed and stated no concerns or recollections of (R2) being physically aggressive with anyone." This report documents V3, Resident Aide stated R2 approached V3 in the hall stating that R1 bit R2's right hand. V3 reported the incident to V5. V5's interview in this report documents R1 and R2 were immediately separated and moved to different rooms and placed on 1:1 supervision. R2 was placed on "15 minute visuals" upon return from the hospital.</p> <p>R1's Baseline Care Plan dated 4/11/22 document R1 ambulates with a rolling walker with supervision. This Care Plan documents on 4/12/22, R1 was placed on 15 minute checks and had a room change after altercation with R2 on 4/11/22 for identified safety risks: safety plan of care.</p> <p>R1's 15 minute monitoring sheets begin with the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>date of 4/17/22 and are ongoing. These sheets do not document 15 minute monitoring for 4/24/22 or 5/2/22.</p> <p>R1's Nurse's Notes document as follows:</p> <p>4/11/22 at 9:00pm documents R1 was in room in bed and got into an altercation with "roommate" (R2) that became physical. R1 defended R1's self by biting R2 when R2 "jumped" on top of R1. R2 put R2's hand over R1's mouth as if R2 was trying to smother R1. R1's fingernail on right hand, third finger "was ripped off during the altercation (1/2 way)." R1's finger had minimal bleeding and no pain but did request PRN Anxiety medication.</p> <p>4/13/22 4:00pm, R1 was seen in the hall having a "verbal altercation" with "another resident." Staff immediately intervened and separated the two.</p> <p>On 4/28/22 at 3:00pm, R1 stated, "yeah, I bit (R2), I (R1) sure did!" R1 stated R1 had a tight bite on R2's hand and was not letting go if R1 could help it and continued to bite R2's hand after R2 had fallen to the floor. R1 stated R2 "tried to beat" R1 up twice and had "jumped on (R1) and flipped out." R1 stated a few days later after the first incident, R2 "saw (R1) coming and confronted (R1)." R1 stated R2 tried to push R1 and V13, Dietary Manager "saw the whole thing" and told R1 that R1 "didn't do anything."</p> <p>R2's Nurses Notes dated 4/13/22 at 4:00pm document R2 was in the hall having a "verbal altercation" with another unidentified "resident" and staff intervened and separated the residents.</p> <p>On 4/28/22 at 2:40pm, R2 stated soon after R1 was admitted to the facility, R1 was mad about</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R2's television but could not remember if it was the volume or channel. R2 stated one evening, R1 was throwing stuff at R2's television so R2 went to find a staff member to talk to R1. R2 stated after R2 found V5, Licensed Practical Nurse (LPN) and told V5 what was going on with R1, R2 went back to the room. R1 continued to throw stuff at R2's television so R2 went to R1's side of the room as R1 was lying in bed and R2 attempted to remove items from R1's hands so R1 would stop. R2 stated R1 grabbed R2's hand and "chomped down" and bit R2's right hand and would not let go of R2's hand. R2 stated R1 hit R2 and R2's glasses "flew off" and R2 fell to the floor while R1 continued to clench R1's teeth on R2's hand. R2 stated R2 had to yank R2's hand out of R1's mouth as R2 was on the floor. At this time, R2's right hand was noted to have a small open puncture wound to under the right thumb. R2 stated R2's right hand was swollen, bruised, painful and had teeth marks and the skin was broken. R2 stated the incident was very traumatic for R2. R2 stated "not even a week later" R1 "rammed" in to R2 with R1's walker in the hall while R2 was ambulating. R2 didn't know R1 was behind R2 at the time. R2 stated V12, Dietary Manager came to help. R2 stated R2 turned around and asked R1, "why did you bang (run/hit) into me, quit banging into me." R2 stated when R2 attempts to leave R2's room, R2 checks around for R1 and if R1 is in the dining room or where R2 is headed, R2 goes back to R2's room in attempt to avoid R1. R2 stated R2 is "afraid of (R1)" and that R2 does not trust R1.</p> <p>On 5/3/22 at 9:40am V13, Physical Therapy Assistant (PTA) stated R1 and R2 were "maybe about 10 feet" from each other on 4/13/22 in the hall when V13 first looked down the hall while assisting with therapy. V13 looked up again and</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>looked down the hall and observed R1 "run in to" R2 from behind with R1's walker. R2 turned around and asked why R1 hit R2 with R1's walker. The verbal altercation began to escalate. R1 went to pick up R1's walker and swing it toward R2 after the incident but I am unsure if contact was actually made. R1 and R2 were arguing and "exchanging" words. Their tone was "not nice", and neither were their words. V13 stated V13 called for assistance when R1 and R2 began to escalate and R1 picked up walker and began swinging it toward R2.</p> <p>On 5/2/22 at 1:25pm, V12, Dietary Manager stated R1 antagonizes and starts the situations. R1 was calling R2 "slurs" including "b****" during an altercation in the hall. V12 stated R1 likes using the word "retard" and was calling R2 a "retard" at that time in the hall as well. V12 stated R2 was walking down the hall toward R2's room, not facing the direction of R1 and R1 was behind R2. V12 stated R2 has told V12 R1 is worried about coming out to dining room when R1 is here and R1 stating "that crazy b**** (R1) is gonna jump me (R2.)"</p> <p>On 5/2/22 at 3:00pm, V1 (Administrator) stated V1 was notified that R1 and R2 "literally physically hurt each other" at 8:08pm on 4/11/22. R2 showed V2 (DON) R2's finger where the nail had been ripped off. V1 stated R1 has never had a history of physical abuse/aggression while a resident at the facility. V1 stated the facility did not send R1 out for psychiatric evaluation, but R2 had been. R1 had a broken fingernail, "not too severe." V1 stated R2 had marks from where R1 bit R2 on R2's hand and that the emergency room had cleaned the wound. V1 stated V1 was told R2 had "teeth marks" from R1 biting R2. V1 stated the physical abuse between R1 and R2 on</p>	S9999		

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S9999	Continued From page 6 4/11/22 was substantiated. V1 stated on 4/13/22, R2 was in front of R1 and R2 was heading to toward R2's room and R1 "bumped" into R2, "(V1) think by accident." R2 turned around and "said something" to R1. V13, Physical Therapy Assistant (PTA) reported R1 and R2 bumped into each other and were having a verbal altercation. V1 stated "it wasn't really anything" but V13 wanted to make sure V13 reported it to the facility. (B)	S9999		