STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: _____ B. WING _____	C 02/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNERS GROVE REHAB & NURSING	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

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S 000	Initial Comments Complaint Investigation 2571074/IL186063 - 330.710a) cited Facility Reported Incident of 2/07/2025- IL186281- 330.710 a) cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) Section 330.710a) 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to protect a resident from abuse, by not following procedures as outlined in their policy. This applies to 1 of 3 residents (R1) reviewed for abuse incidents. The findings include: The facility reported to the department a resident-to-resident altercation that occurred on	S9999		

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February 7, 2025.

The final report dated February 12, 2025, showed R1 sustained a left hip fracture after being pushed to the ground by R2 while both residents were in the dining room. R1 was sent to the local hospital via emergency services and underwent surgical repair of the fractured hip. The report also showed when R2 was interviewed regarding the interaction with R1. R2 stated "she bothers me, so I pushed her."

The medical record showed R1 was admitted to the facility on July 1, 2024, with multiple diagnosis including abnormalities of gait and mobility, muscle weakness generalized, dementia in other disease, unspecified psychosis, epilepsy unspecified, moderate protein-calorie malnutrition, history of falling, fracture of the superior rim of left pubis, dysphagia, nontraumatic chronic subdural hemorrhage and essential hypertension. R1's BIMS (Brief Interview for Mental Status) assessment dated January 29, 2025, showed R1 had severe cognitive impairment. R1's level of care determination dated January 30, 2025, showed score of 3, moderate assistance required with daily living activities. R1's risk assessment for wandering dated July 1, 2024, showed R1 was at high risk for wandering.

R1's service plan contained a goal regarding behavior dated July 9, 2024, with interventions that included "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Validate feelings. Divert attention or use relationship-based redirection. Remove resident from situation and take to or suggest alternate location as needed. Observe and monitor behavioral expression episodes and

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attempt to determine underlying cause."

R2's medical record showed R2 was admitted to the facility on May 30, 2023, with multiple diagnosis including Alzheimer's disease, type 2 diabetes, chronic diastolic congestive heart failure, hypertensive heart disease, anemia in chronic disease, bradycardia, chronic kidney disease, cirrhosis of the liver, and anemia.

R2 had a BIMS assessment dated January 29, 2025, that showed R2 was severely cognitively impaired. R2 had a determination of level of care assessment completed on January 29, 2025, that showed R2 needed moderate assistance with activities of daily living.

R1 and R2 reside on the memory care unit.

On February 14, 2025, at 2:38 PM, V8 (Staffing Coordinator) stated the staffing pattern for the day shift staff for the memory care unit included 3 staff, one nurse and 2 caregivers, one of whom may be a CNA (Certified Nursing Assistant). V8 provided the staffing for February 7, 2025, as worked. There were 3 staff on the memory care unit, V5 (LPN), V6 (agency CNA) and V7 (Caregiver). V8 stated she is a CNA and starts her shift between 6:00 AM and 7:00 AM but does not assist residents at breakfast.

On February 14, 2025, at 12:22 PM, V7 stated she was R1's caregiver on February 7, 2025. V7 stated she assisted R1 to get dressed before breakfast around 6:50 AM. V7 stated R1 told her she had not slept well, and V7 stated R1 was not having a good day. V7 stated R1 was agitated. V7 stated she reported to V5 that R1 was agitated. R1 had breakfast around 7:00 am with her usual peers and at her usual table. V7 stated

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V5 instructed V7 to direct R1 to a chair near the nurses' workstation so V5 could monitor R1 after she ate her breakfast. V7 stated, that R1 had a behavior of pushing the dining room chairs and tables around but that behavior usually happened in the evening. V7 stated on the morning of February 7, 2025, V6 (Agency CNA) was assisting R8, around 8:00 AM, that is when R8 likes to get up. V7 stated V5 was passing out the medications around 8:00 AM. V7 stated she went to deliver a breakfast tray and assist another resident to get dressed for the day when she left the dining room at 8:09 AM. V7 stated it would be nice to have another staff available to monitor the residents in the dining room while the caregivers are getting residents up for breakfast, serving trays, and the nurse is busy giving out medication.

On February 14, 2025, at 11:27 AM, V3 (Community Manager) and V9 (Community Relations Director) showed the surveyor a video recording of February 7, 2025, beginning at 8:00 AM. V3 and V9 identified the residents and location of events in the video. The video showed R2, seated in a wheelchair at a dining table across from R3 and V7 serving R2 her breakfast tray at 8:00 AM. The video showed V5 administering medications to R7 as R7 was wandering throughout the dining room at 8:06 AM. At 8:08 AM, R2 and R3 were seated at the same table across from one another. R2 appeared to engage in conversation with R3. R2 appeared agitated and in response R3 pushed herself back away from the table but remained near the table. At 8:09 AM V7 leaves the dining room carrying a meal tray. At 8:10 AM, R1 enters the dining room from the direction of the nurses' work area, and no staff intervenes. R1 was pacing around R2 and R3's table. R1 was moving

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napkin from the table in front of R3 to the other end of the table. R1 was pushing 2 chairs away from each end of the table. R1 continued to pace around R2's table until 8:17 AM. R1 then pushes a dining table toward the back of R2's wheelchair. R2 was seen standing up from the wheelchair and walking toward R1. At 8:18 AM, R2 approached R1 in an aggressive manner and pushed R1. R2 pushed R1 so hard that both residents fell to the floor. R2 was able to get herself to a standing position. R1 was unable to get up from the floor. There was no staff seen in the dining area between 8:09 AM- 8:18 AM, while R1 was pacing, pushing chairs, and then pushed a table in the dining room. V3 stated after viewing the video, that staff should be monitoring the dining room while residents are gathered there.

V3 stated there are five residents in the memory care unit who pace or wander and identified R1, R4, R5, R6 and R7 as residents with known behavior of wandering.

The January Resident Council Meeting dated January 30, 2025, showed under Nursing/CNA a concern "Residents were expressing concern for not being assisted before breakfast, helping to get dressed and up for the day."

The facility's policy titled "Abuse", undated, showed "Policy: This organization recognizes that each resident has the right to be free from abuse, neglect ...Definitions ...Abuse-the willful infliction of injury ...willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ...3. Prevention ...g. The organization will maintain protocols and procedures to identify, correct and intervene in

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S9999	Continued From page 5 situations in which abuse, ...is more likely to occur...ii. The deployment of staff on each shift, in sufficient numbers, to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs ...iv. The assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms ...residents with communication disorders ...v. The organization will review adverse outcome reports to maintain a safe environment for residents and staff." (A)	S9999		