

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
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NAME OF PROVIDER OR SUPPLIER VILLAGE AT VICTORY LAKES, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1055 EAST GRAND AVENUE LINDENHURST, IL 60046
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.695b)1) 300.1210b) 300.3240a) 300.3240b) 300.3240e)</p> <p>Section 300.695 Contacting Local Law Enforcement</p> <p>b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:</p> <p>1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor;</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)</p> <p>e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to:</p> <p>1) prevent 1 resident (R1), from being physically, verbally and mentally abused by E5 (nurse aide), on 9/11/13 and E3 (charge nurse), on approximately 9/01/13. Facility also placed 19 cognitively impaired residents (R1, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20 and R21), residing on the facilities "Memory Care Unit," at risk for being</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>abused 9/01 - 10/01/13 and all 98 facility residents were at risk 10/03/13 -10/11/13. E3 and E5 were terminated 10/11/13.</p> <p>2) The facility also failed to ensure that 2 alleged violations involving mistreatment and abuse of a resident (R1) were immediately reported to facility administrator. Facility also failed to take corrective action when these alleged violations were verified during facility's abuse investigations.</p> <p>R1 was physically, verbally and mentally abused by E5 (nurse aide), on 9/11/13 and E3 (charge nurse), on approximately 9/01/13.</p> <p>On 9/11/13, E5 approached R1, without verbally communicating with the resident and proceeded to physically restrain R1 in tightly wrapped sheets, securing both arms against the sides of the body, rendering R1 unable to move, causing increased agitation and mental distress.</p> <p>On "approximately 9/01/13", E3 responded inappropriately with R1 while the resident was displaying behaviors of screaming out. E3 roughly transferred R1 from a recliner to a wheelchair, yelled and screamed at the resident, involuntarily secluded the resident behind a closed door in a dark office, physically mishandling R1 by "grabbing the resident by the shoulders and shaking R1, loudly telling the resident to stop screaming." While R1 continued to scream, E3 started mimicking and screaming at R1.</p> <p>The facility staff failed to report the above witnessed abuse incidents from dates of incidents 9/01/13 and 09/11/13 until 09/26/13.</p> <p>After facility administration found abuse allegations about E5 and E3 to be valid, E5 and E3 were allowed to continue providing hands on care to facility residents 10/02 - 10/11/13.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>These failures resulted in R1 experiencing mental and psychological harm. These failures also placed 19 cognitively impaired residents (R1, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20 and R21), residing on the facilities "Memory Care Unit," to be at risk for being abused 9/01 - 10/01/13 and all 98 facility residents at risk 10/02 - 10/11/13.</p> <p>The Findings include;</p> <p>According to the face sheet in the medical record R1 is a 93 year old female with diagnoses including Alzheimer's Disease and Dementia with Behavioral Disturbance. According to the MDS (Minimum Data Set) completed 08/2013 R1 is rarely/never able to make herself understood and is rarely/never able to understand others. R1's cognitive skills are severely impaired and she is completely dependent upon staff for all ADLs (activities of daily living).</p> <p>1) On 10/17/13 at approximately 2:00pm E6, CNA (Certified Nurses Aid) stated during interview that she was hired at the facility on 09/04/13. E6 started on the memory care unit on 09/11/13 and was assigned to train with E5, CNA. This was the first and last time E6 worked with E5. E6 stated, I introduced myself to E5 at 2:30pm. E5 said we have to toilet residents. We entered R1's room. R1 was sitting in a recliner and she (E5) said (in Spanish) we are gonna transfer her. E6 asked E5 if she was going to explain to R1 what she was about to do. E5 said no, it will only agitate her. E5 further stated that the residents are just filthy barn animals. E5 continued to converse in Spanish which seemed to increase R1's agitation. At bed time we toileted</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>R1 and E5 again did not explain to R1 what she was going to do. R1 was biting and scratching at us. E6 tried to calm R1 down and E5 said, What do you care? It doesn ' t matter, we have to get this done. When we put her to bed E5 asked E6 to get an extra sheet. E5 said she was gonna show E6 how we wrap R1 because she tears off her diaper and rips it up. E5 folded the sheet, put R1's arms to her sides, rolled R1 from side to side in the bed and proceeded to tightly wrap R1's body like a mummy. R1 could not move and began to scream loudly, " I hate you! I ' m gonna kill you." R1 continued to be very upset. E6 went back to R1's room about an hour later to check on her because she was wrapped so tightly she wanted to make sure R1 could breathe. E6 further stated that she has found R1 to be compliant with care if you just explain what you are going to do. E6 said she did not report the incident right away because she felt intimidated by E5 and E5 had been working there for a long time. But this was so bad, it was just not right. About 2 weeks later I told the nurse what happened.</p> <p>E2, DON (Director of Nursing and Abuse Coordinator) submitted an initial report to IDPH on 09/26/13. A final report of abuse and neglect with a completion date of 10/02/13. In the report E2 interviewed staff members including E5 and E6. E2 documented her interview with E6 who relayed the same information regarding the mistreatment of R1 on 09/11/13. E5 denied the allegations in her statement. E2 stated on 10/17/13 she sent an initial report to the Department of Public Health and sent a letter to E5 (who was on vacation) to not return to work while the investigation was in process. However on 10/02/13 E2 concluded in her investigation that the information provided is inconclusive of verbal, physical abuse and neglect. The report</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>also notes that E5 was returned to work, however to different, more visible unit. During a meeting with facility staff in the conference room on 10/17/13 E2 stated, that the reason she wrote on the investigation that the information provided was inconclusive was because she was directed to by HR (corporate human resource person, E12). E2 further stated that she felt the abuse had occurred and E5 should have been fired but we couldn't. E12 directed us to do this, we were all shocked.</p> <p>E10, RN (1st floor manager) stated during interview on 10/17/13 that she also helped with the abuse investigation involving R1. E10 said that while interviewing E4 (CNA), E4 told E10 about another situation that had occurred recently on the memory care unit. E4 said that a couple weeks ago, not sure of the exact date at dinner time around 5:30pm R1 was in the dayroom in a recliner. R1 was screaming and E3, (LPN) put R1 in a wheelchair and brought her into the nursing office. R1 was still screaming and E3 was screaming back at her and shaking her.</p> <p>On 10/17/13 E1, (Administrator) was asked about the abuse allegations against E5 and E3. E1's reply was " We should have termed them. " Timekeeping reports were reviewed and it was determined that after the incident occurred on 09/11/13 E5 worked with residents for 8 more days, 09/12/13, 09/14/13, 09/15/13, 09/16/13, 09/18/13, 09/19/13 and 09/20/13. E5 was on vacation from 09/21/13/ thru 10/01/13. E5 worked again on 10/04/14 and 10/07/13 on a different resident floor, (after the facility became aware that abuse had occurred.)</p> <p>E3's timekeeping report notes that after the abuse incident of approximately 09/01/13, E3 worked directly with residents on 09/03/13, 09/04/13, 09/05/13, 09/07/13, 09/08/13, 09/10/13, 09/11/13, 09/12/13, 09/13/13, 09/19/13, 09/21/13,</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>09/22/13, 09/24/13, 09/25/13, 09/26/13, 09/27/13, 09/30/13, 10/01/13, 10/02/13, 10/03/13 and 10/05/13. E3 was not terminated until 10/11/13.</p> <p>2) On 10/17/13 at 10:10AM, E2 (DON), during interview stated "on 10/01/13, E4 (nurse aide), reported that on approximately 9/01/13 during the dinner meal on Memory Care unit, E4 witnessed the following: R1 was sitting in a recliner in the dining room, agitated and screaming out loud. E3 grabbed R1 out of the recliner and put her in a wheel chair, then took R1 into a darkened nursing station office and closed the door behind them. R1 continued to scream in the office and E3 yelled back at R1, mimicking her. E4 also said that E3 grabbed R1's shoulders and started shaking the resident while telling R1 to stop screaming." E4 said, 30 minutes later, E3 brought R1 back to the dining room and served R1 her dinner tray but the other residents had already finished eating. After returning R1 to the dining room, E3 said out loud; "Let me know if any other residents need to be taken into the office." E2 said that E9 and E11 (nurse aide), were also present during this incident. E2 said that E3 denied ever putting R1 in the nursing office for screaming. E2 said the exact date of this incident is not known.</p> <p>On 10/17/13 at 4:29PM, during a telephone interview, E11 (nurse aide), stated that she witnessed E3 take R1 into the nursing station office during a dinner meal for screaming and spitting at her. E11 said that R1 was very agitated during the transfer from recliner to wheel chair. E11 observed E3 holding R1 with open hands to keep R1 from hitting her. E11 validated contents of her 10/01/13 written statement.</p> <p>On 10/17/13 at 10:30AM, E1 (Administrator),</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>during interview stated " About 2 weeks prior to 9/11/13, exact date unknown, E3 was observed grabbing R1 by the shoulders, placing R1 in a locked office with the lights turned off. E1 said there were several witnesses to this incident and could see and hear E3 mocking R1 through the office window. E1 said that "we should have terminated E3 but facilities home office said we could not terminate her because we did not have enough evidence." E1 also said E3 was allowed to come back to work after 10/02/13. E1 said E3 denied doing anything wrong to R1.</p> <p>10/18/13 at 11:15AM, during a telephone interview, E9 (nurse aide), stated that she witnessed E3 remove R1 from the dining room one evening (date unsure), and place R1 in the nursing station office due to screaming behaviors. E9's written statement in facilities 10/01/13 abuse investigation validates the above interview.</p> <p>E3's 10/02/13 written statement and E2 and E1's 10/17/13 interviews conclude that E3 denied ever taking R1 into the nursing station office due to screaming behaviors during a meal.</p> <p>Facilities abuse investigation related to R1 and E3, validated the above information obtained in staff interviews. The investigation documented the results were inconclusive for verbal, physical and restraint use and the " staff member returning to work 10/04/13."</p> <p>On 10/17/13, during individual interviews, E2 at 10:20AM, E1 (Administrator) at 10:30AM and E10 at 1:30PM , all stated that on 10/01/13, E1, E2 and E10 all agreed that the alleged abuse incidents to R1 on 9/01/13 by E3 (nurse) and on 9/11/13 by E5 (nurse aide), were validated and they agreed to terminate E3 and E5. E1, E2 and E10 also said that as a final determination by</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>facilities "Home Office", E3 and E5 were not terminated and allowed to return to work in same positions, providing hands on patient care.</p> <p>On 10/17/13 at 5:00PM, E7 (executive director), stated "We have set protocol to follow before terminating an employee. E3 and E5 have had very good performance appraisals up to these incidents. So they were allowed to return to work."</p> <p>During 10/17/13 individual interviews, E2 (DON) at 10:10AM and E6 (nurse aide), at 2:00PM, both stated that on 9/11/13, E6 observed E5 (nurse aide) abusing R1. E2 said she was not notified of this incident until 10/01/13. E6 stated, "I did not report the incident to anyone until after 9/25/13, when E5 went on vacation, because I was so intimidated by E5. When E5 went on vacation, I asked the other Memory Care staff if they tightly wrap R1 up in sheets at night and they said No. I started working at facility on 9/04/13 and was being oriented to the Memory Care unit by E5, at the time of this incident. E5 had been working there a long time."</p> <p>On 10/17/13 at 10:10AM, E2 stated, "on 10/01/13, E4 (nurse aide), reported, that on approximately 9/01/13, during the dinner meal on Memory Care unit, E4 witnessed E3 abusing R1. E2 said that E9 and E11 (nurse aide), were also present during this incident. E2 said, the exact date of this incident, is unknown.</p> <p>The facility staff failed to report the above witnessed abuse incidents immediately. The 9/01/13 incident involving E3 and R1 was not reported until 10/01/13 and the 9/11/13 incident involving E5 and R1 was not reported until</p>	S9999		

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S9999	Continued From page 9 9/25/13. R1's 9/25/13 and 10/01/13 abuse investigation reports failed to include documentation that local police had been notified of the abuse allegations. (A)	S9999		