

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ILL6005623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
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NAME OF PROVIDER OR SUPPLIER LYDIA HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 13901 SOUTH LYDIA ROBBINS, IL 60472
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(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
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S 000	Initial Comments Incident Report Investigation to incident of 1/19/17/IL91890- 300.3240a)b) Complaint #1720726/IL91596- no findings	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.3240a) 300.3240b) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) 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) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from abuse and failed to ensure staff immediately reported an incident of abuse to the facility administrator, for one of three residents (R1) reviewed for abuse in the sample of 6. The findings include:	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>Facility's Critical Incident Report, dated 1/18/17, states on 1/18/17 at 9:00 AM, R1 was physically aggressive toward property and staff and sustained a laceration to his occipital area. R1's Progress Note, dated 1/18/17 at 10:48 PM, states R1 was transferred to the hospital for evaluation and treatment. R1's Progress Note, dated 1/19/17 at 5:48 AM, states R1 returned to the facility with 5 sutures intact to his head.</p> <p>Facility's Critical Incident Report, dated 1/19/17, states on 1/19/17 at 7:00 AM, R1 stated he was beat up by two staff.</p> <p>Facility's Statement of Investigation, dated 1/19/17, states on 1/18/17 at 9:30 AM, E2 (Director of Nurses) received a call that R1 was physically aggressive toward staff. E4 (Peace Officer) and E5 (Peace Officer) had to restrain R1 using crisis prevention (CPI) techniques, causing R1 to fall to the floor and sustain a laceration to his head. On 1/19/17, E1 (Administrator) and E2 (Director of Nurses) investigated the incident. During the course of this investigation R1 stated he was slapped by a staff member. Video tape indicated R1 was seen walking up and down the hall. R1 was then escorted to the chart room by staff. E4 was seen swinging his arm out in the direction of R1, then R1 attempting to hit E4. E5 then entered the room. E4 and E5 then attempted to restrain R1, with E5 pulling his arm back and striking in the direction of R1. R1, E4, and E5 then left the chart room and R1 fell to the floor. E7 (Peace Officer) was standing at a nearby counter. Police Department was called and investigation turned over to the police. E4 and E5 were taken into custody by the police. Effective 1/19/17, E4 and E5 were terminated for abuse, E6 (Nurse) was terminated for failure to report an incident of abuse, failure to follow facility</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>policy/procedure, and falsifying information/documentation, and E7 was terminated for failure to report an incident of abuse.</p> <p>On 2/21/17 at 12:30 PM, E1 (Administrator) stated she was unable to determine how R1 received the laceration to his head. E1 stated E5 admitted to the police that E5 made physical contact with R1. E1 stated review of the video indicated abuse was suspected and E6's account of events was not accurate.</p> <p>On 2/21/17 at 12:20 PM, E2 stated E6 falsified the story, along with not reporting abuse, and was thus terminated. E2 stated the video of the incident was turned over to the police.</p> <p>On 2/22/17 at 9:02 AM, R1 stated he was unable to recall any information regarding the incident. R1 stated he had received sutures to his head but could not recall how it happened.</p> <p>The facility's Abuse Prevention policy, dated December 2013, states employees are to immediately report any incident or suspicion of abuse to an immediate supervisor, or the administrator. Staff are obligated to prevent and report abuse.</p> <p style="text-align: center;">(B)</p>	S9999		
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