

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ILL6000764	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2017
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NAME OF PROVIDER OR SUPPLIER BAYSIDE TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 SOUTH LEWIS AVENUE WAUKEGAN, IL 60085
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Z 000	<p>COMMENTS</p> <p>Complaint Investigation #1711654 / IL# 92661</p> <p>Statement of Licensure Violations</p>	Z 000		
Z9999	<p>FINDINGS</p> <p>Statement of Licensure Violations 300.3240 a) 300.3240 b) 300.3240 e)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>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)</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>This REQUIREMENT was not met as evidenced by:</p>	Z9999	<p>Attachment A</p> <p>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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Z9999	<p>Continued From page 1</p> <p>Based on interview, and record review the facility failed to prevent, immediately report, investigate, and immediately remove alleged employees from further contact with residents after an incident of mental abuse.</p> <p>This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 6.</p> <p>The findings include:</p> <p>On March 21, 2017 at 1:15 PM, R1 said he entered the dining room on Saturday (March 18, 2017) at 5:20 PM and sat down at the table next to R2 to talk to her briefly. R1 said immediately a kitchen staff member (E7) shouted at him in an angry tone of voice that he was not to be sitting there. R1 said he replied to E7 that he would only be there for a minute at the most. R1 said E7 then said to him in an angry voice to get away from the table right now. R1 said E8 RSA (Rehabilitation Services Associate) was standing next to the meal tray return window serving coffee and began quickly walking towards him in an aggressive manner shouting in an angry tone of voice "When a staff member tells you to do something you do it." R1 said he immediately got up and left the dining room. R1 stated, "I felt physically threatened and was humiliated in front of other staff and fifty other residents." "I didn't eat dinner that night and didn't sleep because it upset me greatly." R1 said he did not report the incident to anyone at the time that it occurred because he wanted to compose his thoughts and write a letter to give to the administrator.</p> <p>On March 22, 2017 at 10:20 AM, E4 (Dietary) said (at dinner on March 18, 2017) E7 (Dietary) was yelling and screaming at R1. E8 was serving coffee, went to the table and was screaming too.</p>	Z9999		
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Z9999	<p>Continued From page 2</p> <p>R1 got up from the table and did not come back to the table that meal. E4 said nobody was in the facility to report it to because it was a Saturday. E4 said she wrote a statement the same day but nobody was there.</p> <p>E4's signed statement dated 3/18/17 showed, "To whom concern: I called by supervisor to tell her to talk to (E7) because she is too loud."</p> <p>On March 22, 2017 at 12:45 PM, E3 (Food Service Supervisor) said she received a call at 7:00 PM on March 18, 2017 from E4. E4 was upset about E7 screaming at residents. E3 said she told E4 to write a statement and give it to E6 (Case Manager on duty for the weekend). E3 said she talked to E7 who denied yelling at the residents. E3 said E7 had written a statement and had given it to the Case Manager on duty for the weekend (E6). E3 said she educated E7 about tone of voice when speaking to residents. E3 said she only talked with her dietary employees. E3 said she did not talk to other staff or residents because the case managers would follow up on it to investigate further.</p> <p>On March 22, 2017 at 1:10 PM, E6 (Case Manager) said she was the case manager on duty Saturday, March 18, 2017. E6 said E7 reported that R6 became agitated when E7 was telling R6 to get in line for lunch, R6 did not like it and R6 ripped the book she was holding. E6 said that no one reported an incident about a kitchen person yelling at R1. E6 said if the incident had been reported, she would have spoken to the resident and staff involved.</p> <p>E7's March 18, 2017 signed statement showed, "I said you [R6] cannot sit here you have to get in your group and she scream at me and say for me to shut up and she ripped up her book that she</p>	Z9999		
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Z9999	<p>Continued From page 3</p> <p>was writing in. And walking and was still screaming at me."</p> <p>On March 22, 2017 at 12:05 PM, R2 said at supper time on Saturday (March 18, 2017) R1 sat next to her in the dining room to give her some information about public transportation. R2 said E7 was rude and nasty telling R1 to get up and get out of the tables. R2 said E8 came up very threatening and looked like he was going to be aggressive. R2 stated, "[R1] is good natured. He follows the rules. To be treated like that wasn't right." R2 said she did not report the incident to anyone at the time that it occurred.</p> <p>On March 22, 2017 at 11:00 PM, R4 said that E7 has a loud demeaning voice when she speaks to residents about where to wait before meals.</p> <p>On March 22, 2017 at 12:00 PM, E5 (CNA/RSA Certified Nursing Assistant/Rehabilitation Services Associate) said the dining room has no assigned seating. The dining room has three tables designated for residents who need assistance with carrying their trays. Residents using canes or for some reasons are unable to carry their own meal tray can sit at the designated tables and staff will bring their meal tray to them. E5 said if she were to see any staff yelling at residents she would report it immediately to her supervisor.</p> <p>On March 22, 2017 at 1:20 PM, E2 (Director of Nursing) said staff are to report any abusive incident right away. The alleged staff is sent home immediately until the incident is investigated to protect the resident from perceived or potential harm.</p> <p>On March 22, 2017 at 11:30 AM, E1</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>(Administrator) said she was told in the Monday (March 20, 2017) meeting about a resident (R6) acting out and shouting over the weekend. E1 said that R1 told her yesterday (March 21, 2017) that R1 was writing a letter with some concerns for her to review. E1 said she received the letter from R1 today and after reviewing the information has suspended E7 and E8 pending the outcome of an investigation. E1 said she was only aware of one incident of a residents' (R6) acting out behavior that occurred on March 18, 2017. Two things were happening and only one was reported.</p> <p>The facility's March 2017 schedule showed that E7 finished working her shift on March 18, 2017 and worked the next four days (March 19-21) before being suspended. E8 finished working his shift on March 18, 2017 and worked the next two days (March 19 & 20) before being suspended.</p> <p>The facility's undated Abuse Prevention Program policy states, "to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This will be done by: establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse; implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively in making the necessary changes to prevent future occurrences; and filing accurate and timely investigation reports."</p> <p>(B)</p>	Z9999		