

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/10/2017
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NAME OF PROVIDER OR SUPPLIER GROVE AT THE LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2534 ELIM AVENUE ZION, IL 60099
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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
S 000	Initial Comments Complaint investigation 1714013/IL95213	S 000		
S9999	Final Observations Licensure Violations: 300.610 a) 300.3240 a) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on interview, and record review the facility failed to ensure a resident with a diagnosis of	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

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>schizoaffective disorder was communicated with effectively and treated fairly. This failure resulted in R1 being verbally abused by a staff member on June 25, 2017.</p> <p>This applies to 1 of 8 residents (R1) reviewed for abuse in a sample of 8.</p> <p>On July 6, 2017 at 9:50AM, the sign posted on the resident's outdoor roof top access door shows, Penthouse Deck Hours 9:00AM to Noon, 1:00PM to 9:00PM.</p> <p>On July 6, 2017 at 9:30AM, R3 said, E5-Activity Aide started yelling and screaming at R1 and R1's family. I was here when it started. R1 tried to leave the area but E5 kept following R1 while calling R1's mom a prostitute.</p> <p>On July 6, 2017 at 10:00AM, R2 said, if you are done smoking you can stay on the deck. You can't smoke, but you can stay out there.</p> <p>On July 6, 2017 at 1:15 PM, R7 said, " I was in tears on June 25, 2017, it was too much, I was in tears." E5 provoked the incident. E5 picked up a cue stick. R1 was sitting over there, and E5 wanted R1 to go inside. R1 was not smoking. The language was horrible. E5 picked up a pool cue and threw a phone at R1. Everyone was sitting out here. Why E5 decided to go off on R1 is unknown.</p> <p>On July 6, 2017 at 1:20PM, R8 said, " we didn't know what was going on here. E5 picked up the phone receiver and threatened to hit him, then E5 picked up a pool cue. "</p> <p>R1's Minimum Data Set dated May 19, 2017 shows, R1's Brief Interview for Mental Status 15</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>(Cognitively Intact). R1 was no longer residing in the facility during this investigation. Several attempts to contact R1 by telephone were made. Messages were left twice on July 6, 2017 and again on July 10, 2017. R1 did not return any of the calls. Under the same circumstances a reasonable person would have felt insulted, angry, and intimidated when the staff member began yelling at them, calling their mother names, and threatening to harm them.</p> <p>R1's General Progress Note dated June 25, 2017 at 7:13 PM, shows, a nurse and two Certified Nursing Assistants (CNA) responded to a request for assistance from an Activity Aide. A resident and activity aide were found yelling and screaming at each other. Both the resident and the activity aide began to get very aggressive towards each other and towards staff members involved in trying to stop the feud. The activity aide was holding the telephone, standing far away from the resident, yelling and screaming at the resident. The arguing escalated and continued for about 15-20 minutes before writer could get resident on the elevator safely.</p> <p>R1's undated, written statement shows, at the facility on June 25, 2017 R1 requested to continue to sit outside on the deck without smoking and visit with R1's mother. E5 demanded R1 leave the deck. E5 then called R1's mother a bitch. R1 admits to becoming angry and exchanging words with E5. E5 then called R1's mother a crack-head prostitute. R1 alleges E5 grabbed a pool stick and threatened to kill R1. R1 alleges E5 hit R1 in the head and hand with a telephone.</p> <p>The facility's abuse investigation report dated</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>June 29, 2017 for the June 25, 2017 incident between R1 and E5 shows, Abuse Substantiated.</p> <p>The facility's Abuse and Neglect and Procedure policy dated November 28, 2016 shows, verbal abuse includes but not limited to the use of oral, written, or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Example: name calling, swearing, yelling, threatening harm, trying to frighten the resident.</p> <p>(B)</p>	S9999		
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