Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: ______ B. WING ______	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

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S 000	Initial Comments Complaint Survey: 2379367/IL166515 & 2379298/IL166431	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690b) 300.690c) 300.1210b) 300.3240a) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

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.

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)

These Requirements were not met as evidenced by:

Based on observation, interview and record

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review, the facility failed to ensure that R10 was free from physical, mental, and emotional abuse from an agency staff, V15 (CNA/Certified Nurse Assistant). The facility also failed to implement its policy to keep R10 free from further abuse.

The findings include:

The EMR (Electronic Medical Record) showed that R10, an 81-year-old, was admitted to the facility on 6/28/2023. R10's diagnoses included but not limited to atrial fibrillation, thrombocytopenia, S/P (status post) CABG (coronary artery bypass graft), history of DVT (deep vein thrombosis), iron deficiency anemia, myocardial infarction, obsessive-compulsive disorder, CAD (coronary artery disease), anxiety and depression.

The MDS (Minimum Data Set) dated 9/21/2023 showed that R10 was moderately impaired in cognition with BIMS (Brief Interview Mental Status) and score of 12/15. R10's functional status showed she required one-person physical assistance with ADLs (Activities of Daily Living). The MDS showed that R10 was not delusional, no psychosis, no negative behavior and was not rejecting care.

The care plan dated 9/21/2023 showed that R10 had no negative behavior such as being hostile, aggressive and or combative.

The progress notes dated 11/7/2023 at 6:00 P.M. documents "Bruising noted to left inner forearm from base of wrist to elbow and on left bicep area. Head to toe assessment done...Family member made aware.... (R1's MD) made aware. Order given to obtain x-ray to left arm and PT/INR in morning 11/8/23." Review further of the progress

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notes showed that last documentation of the progress notes before 11/7/2023 was 11/2/2023. The documentation for 11/2/2023 was related to medication order. The EMR/progress notes showed that there was no documentation regarding the bruise not until 11/7/2023.

The facility's incident report dated 11/7/2023 at 4:57 P.M. showed there was an allegation of resident abuse that occurred 11/5/2023. The resident referred to was R10 and V15 (CNA/Certified Nurse Assistant) as the perpetuator. The incident report showed that on a 11/7/2023 at around 4:00 P.M., V25 (Transportation Coordinator/Unit Clerk) reported that R10 had stated that "(V15) was rough during patient care."

On 11/8/2023 at 10:30 A.M., together with V2 (Director of Nursing), R10 was observed and interviewed. R10 was alert and oriented and had responded to questions coherently. R10 was aware of time, name and place and current events. R10 showed her left arm. R10's left forearm was observed with a bruise that extended from her wrist to the elbow, the bruise was irregular in shape, the color was dark purple/blue. There was no other visible bruise noted on R10's extremities. R10 said "this bruise was caused by rough handling from (V15, CNA from staffing agency), I was pulled from my left arm by (V15) with force on 11/5/2023 around 9:00 A.M. I thought (V15) was not to take care of me because of an incident that occurred on 11/1/2023 when (V15) took care of me during the evening shift. (V15) had a nasty attitude, very abrupt when she talked, no respect, and she broke and yanked my bed rail." R10 pointed her bed's left upper rail that was tied with a rope. R10 said "I told everyone (staff) I don't remember

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each of their names but told (V19/nurse) since he runs the ship regarding (V15) not to return to facility anymore because she had handled me roughly, with nasty attitude, and (V15) even said she doesn't care, she can be assigned anywhere because she is from staffing agency." R10 continued to state that "on 11/5/2023, (V15) came in early morning, with nasty attitude like she does not want to be at work, verbally abrupt when questions were asked, or she does not answer at all, and will not listen to my request that I wear a blue color brief and not yellow and (V15) insisted on putting the yellow brief. I am scared of her (V15) and I do not want her to take care of me." R10 said she called V20 (Receptionist on Duty) in the morning of 11/5/2023 that V15 should not be assigned to her because V15 was rough handling her and R10 might get hurt. However, R10 said that she was told by V20 that she will inform V21 (RN/MOD/Manager of the Day) when she comes in that day. R10 continued to state that "(V15) pulled my left arm with force when she was getting me out of bed, I felt the pain, then few hours later, I saw this big bruise on my left forearm. (V21) came in around 9:30 A.M. and she acted like she was a MEDIATOR and advised me to say PLEASE when asking for care. (V15) continued to give me care, and other residents (R4, R6, R14) and they saw me how upset I was because they also complained how (V15) treated them. I know (V15) did hurt me intentionally because she jerked my arm."

On 11/8/2023 at 2:00 P.M., R10 was sitting in the activity department and was interviewed again about the incident involving V15. R10 repeated the same account of events as stated during the earlier interview. During this time of interview, V23 (Police Officer) came in and said he had to ask R10 for few more questions. R10 had

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agreed. V23 said he saw R10 the day before (11/7/2023) for initial investigation of physical abuse by V15. V23 and R10 gave permission for the surveyor to stay during V23's interview. R10 was consistent with her statement stating that V15 had rough handled her during care in the morning of 11/5/2023. After the interview, R10 was assisted back by a staff to the activity department and R10 was seen sobbing, tears flowing down her cheeks, was shaking, and said, "I am scared of (V15) she might come back again, and I do not want other residents to go through what I have been through with her (V15)." During this time R10 was noted to be shaken and other residents came to comfort her. R12 was holding R10's hands continuously consoling her, R8, R13 and R14 also tried to console R10. V2 then removed R10 from activity room and once again, R10 stated, "I want to make sure (V15) she will not take care of me again". R10 was noted to keep asking V2 who would take care of her and that she did not want V15 to provide care since she was afraid of V15.

The following residents were assigned to V15 on 11/5/2023 during the day shift. They were interviewed on 11/8/2023 from 11:00 A.M. to 2:30 P.M. at an intermittent time:

R14 said "I filed a grievance on 11/5/2023 regarding (V15's) that she has bad attitude causing us mental and emotional distress, but up to now, I have not heard from the management. (V15) told me on 11/5/2023 "I am not your CNA, I cannot take care of you, you are so fat." R14 also said that she needs help with transfers and uses a mechanical transfer lift device. R14 also said that she was incontinent of bladder function and that V15 refused to change her incontinence brief and that R14 wore the soaked brief at least 5-6

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hours.

R4 said she requested V15 to pick up condiments that was dropped off from her lunch tray on 11/5/2023. R4 said that V15 responded "I am not your C.N.A." R4 said "(V15) then left the room and does not care at all."

On 11/8/2023 at 4:52 P.M., V20 (Receptionist) said that on 11/5/2023 at around 9:00 A.M., R10 called her via phone and informed that V15 was rough handling her. V20 also said that she that she could tell from R10's voice that R10 was upset. V20 added that R10 was crying and stating that V15 was rough with her and had a "nasty attitude." V20 said she told R10 that she will inform V21 as soon as she arrives at the facility since V21 was the assigned MOD (manager on duty) for the day.

On 11/8/2023 at 4:30 P.M., V21 (RN/Registered Nurse) said that when she arrived at the facility on 11/5/2023 at around 9:30 A.M., she was informed by V20 that R10 was upset due to V15 being rough with care and with a bad attitude. V21 said she went to R10's room around 9:45 A.M. V20 said she saw R10 lying in bed, and V15 pulling up R10's pants. V21 said "I can tell that there was an argument between the two, I saw R10 crying and visibly upset. I helped (V15) get (R10) up and stayed with (R10) for a while since she was crying." Surveyor asked V21 what the argument was, and the reason of R10 being upset and crying. Surveyor also asked if it makes sense for V15 to pull up R10's pants if V15 can do it while R10 was standing up. V21 had no explanation or answer what the argument was and why R10 was upset. V21 said she did not remove V15 from work and V15 continued to work until the end of the shift (10:00PM). V21

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also said she did not report this incident to the administrator, nor had she initiated an investigation for potential abuse.

On 11/8/2023 at 3:45 P.M., V19 (Nurse) said R10 had informed him regarding V15 that she has a nasty attitude and that V15 broke R10's bed rail on 11/1/2023. V19 added that he saw the bed rail on the floor and was detached from R10's bed on 11/1/2023 evening shift. V19 also said that he also worked on 11/5/2023 and that V15 had ignored residents' call lights and will not answer for 35 minutes. V19 showed to surveyor a monitor screen that showed V15 had not responded to residents' call light for 35 minutes. V19 said that V15 had "bad attitude, abrupt, not motivated to work." V19 added that she had texted V16 (staffing scheduler) on 11/5/2023 for V15 not to return to facility since V15 was from staffing agency.

On 11/11/2023 at 8:30 A.M., V16 (staffing scheduler) had validated that V15 had worked double shift (6:00 A.M. through 10:00 P.M.) on 11/5/2023. V16 also confirmed that V15 took care of R10 on 11/1/2023 for the evening shift and morning shift on 11/5/2023.

On 11/8/2023, at 3:00 P.M., V1 (Administrator) said she was only informed regarding alleged physical abuse by V15 towards R10 by V25 (Transportation Coordinator) on 11/7/2023 at 4:00 P.M.

On 11/27/2023 at 10:30 A.M., V20 was asked again regarding the phone call that she had received from R10 on 11/5/2023 in the morning. V20 had verbalized the same statement when first interviewed on 11/8/2023. V20 said R10 called around 9:00 A.M. on 11/5/2023, and that

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R10 said she does not want V15 to take care of her because V15 was rude, and rough when handling R10. V15 also said that R10 was crying and upset. V20 said she told R10 that she will inform V21 as soon as she arrives at the facility. V20 said that she had reported this to V21 as soon as V21 arrived at the facility around 9:30 A.M. V20 added that she had not received abuse training provided by the facility when asked on 11/28/2023.

On 11/27/2023 at 2:35 P.M., V21 was again interviewed. V21 had said that V15 has "bad attitude/loud talking to residents" and that she had reported this to V2 on 11/8/2023. When asked to verify the date, since facility had in initiated the abuse allegation investigation on 11/7/2023 due to a report made by V25 to V1, V21 responded "oh, I must have reported on 11/5/2023 to (V2)."

On 11/27/2023 at 3:00 P.M., V1 and V2 were asked about V21's statement that she had reported to V2 regarding V15's "bad attitude/loud talking to residents." V1 answered that "(V2) would have reported to me immediately if (V21) had reported this to him (V2)." V2 said that V21 had never mentioned anything regarding V15's inappropriate behavior, bad attitude /loud talking to residents." V2 added that he would have reported this to V1 immediately if V21 had informed him. V1 said she only found out the abuse allegation by R10 towards V15 when V25 had reported to her on 11/7/2023.

On 11/27/2023 at 11:30 A.M., V25 (Unit Secretary/Transportation Clerk) said that on 11/7/2023 around 4:00 P.M., R10 had informed her that on 11/5/2023 during the morning care, V15 had roughly handled her, grabbed her left

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arm with force that had caused a huge bruise from the wrist all around the elbow. V25 said she immediately informed nurse supervisor and they both informed V1 on 11/7/2023 at around 4:00 P.M. regarding the allegation of physical abuse by V15 towards R10.

On 11/27/2023 from 4:30 P.M. to 5:30 P.M., at an intermittent time, the following residents were interviewed again. V2 was present during the interview except with R8:

R14, lying in bed in her room. R14 said "I remember you; you are the investigator from the state. I tell you, other staff here are nice, but no way in H*LL that (V15) should come back here nor work in a facility where residents are subjected to abuse. (V15's) licensed to work in a nursing home should be removed, she has a nasty behavior, does not provide care, ignore our needs, have to wait 5-6 hours before our brief be changed, told me to find another nurse or CNA to care for me because I am F*T. (V15) gave me so much aggravation that she is a bully to us, she does whatever she wants and does not listen to our needs. I don't want her here and I hope she goes to jail."

R4, sitting in her chair in her room. R4 said that V15 ignored their needs, she waited prolong hours for her meal and when it was given to her, the food was cold. R4 also said that "(V15) does her own thing, and she does not care to attend to our needs because she said she works from agency, and she can go anywhere."

R8, requested that V2 not present during the interview. R8 said that "(V15) was no good, bad attitude, and intimidating. I am a big man, but she was also a big woman, and with her bad attitude

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she was a bully. The way she (V15) talks to us, and her approach was bad. The staff knows how she was (V15), but she came back and had worked again here."

R10, sitting in her wheelchair in her room. R10 said she remember the surveyor. R10 said "so many people were asking me about this abuse, I am already overwhelmed with questions. The main issue here was that (V15) had jerked my arm, grabbed me roughly (pointed her left arm), and she should have not come back here when she did this to me Sunday (11/5/2023). (V15) was here before that (Wednesday) and broke by bed rail. I told the staff, showed to (V19/Nurse) that my bed rail on the floor because (V15) broke it. I was seen by a shrink because of this but was not seen by the social worker.

On 11/29/2023 at 10:30 A.M., R10 was in her room. R10 was sitting in her wheelchair. R10 said her left arm was still sore from being "jerked and grabbed by (V15). She should be in jail; I would like to pursue criminal charges against her (V15)."

Review of the police report dated 11/7/2023 showed that V15 was charged for aggravated battery and warrant of detention was processed.

The facility's abuse policy dated 7/14/2023 showed "It is the facility's policy to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and through investigations of allegations.... Abuse is willful infliction of mistreatment, injury, unreasonable

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S9999	Continued From page 11 confinement, intimidation, or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm maybe considered abuse. ... Types of abuse: 1. Physical 2. Verbal 3. Mental....9. Injury of unknown origin.... Prevention of abuse: Identify, correct, and intervene in situations in which abuse, neglect...is more likely to occur ...Establish a safe environment.... Supervision of staff to identify inappropriate behaviors, such as derogatory language, rough handling, ignoring residents while giving care...Employee accused must be suspended pending investigation... Reporting... must be reported to the administrator immediately..." (A)	S9999		