

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2024
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NAME OF PROVIDER OR SUPPLIER AMBER GLEN ALZHEIMER'S SCC	STREET ADDRESS, CITY, STATE, ZIP CODE 1704 EAST AMBER LN URBANA, IL 61802
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A 000	Initial Comment Incident Report Investigation IL 176750	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on record review and interview, the establishment failed to ensure resident's are free of abuse and failed to follow it's policy regarding abuse and neglect. This failure resulted in R1 being forced to have care provided while the resident was refusing, resulting in R1 being yelled at by a staff member, having R1's arm pushed away in a rough manner while care was provided. Findings include: R1 was admitted to the establishment on 02-25-2022. R1's diagnoses include major neurocognitive deficit. R1's 07-24-2024 service plan includes documentation that R1 will be assisted with	A6000		

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

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A6000	<p>Continued From page 1</p> <p>behavior management as needed to help decrease anxiety and agitation. The same service plan also includes documentation that R1 requires total assistance with transfers, dressing, and toileting. The service plan includes documentation that R1 requires hospice services.</p> <p>R1's 02-25-2022 Mini Mental Status Exam includes documentation that R1's score is 21 out of 30.</p> <p>R1's 02-25-2022 Global Deterioration Scale includes documentation that R1's score is 3.</p> <p>R1's July and August 2024 observation notes were reviewed. No observations notes were noted for 07-16-2024 through 07-24-2024.</p> <p>The establishment's investigation into the 07-22-2024 allegation were reviewed.</p> <p>The establishment's 07-22-2024 Report of Incident includes documentation that "Staff reported to nurse that employee and resident were in shower room and they heard hollering so checked on resident. Resident was upset about staff member trying to change her and did not want to get changed at this time. Staff member got frustrated with resident and tried to change her anyway. Resident then spit on staff member and staff member said, "you do that again and I'm going to have to do something back." Staff member the left the shower room and clocked out for the day. Staff member has been suspended pending investigation. Witness statements taken from both staff members who witnessed incident." The report also includes documentation that the resident is R1. The report does not include any staff member names or the time the incident occurred.</p>	A6000		

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A6000	<p>Continued From page 2</p> <p>The establishment's investigation includes staff member statements from three staff, E3, E4, and E5; all caregivers.</p> <p>E3's written statement includes documentation of the 07-22-2024 incident. The statement includes documentation that the incident involved R1. Further documentation is that R1 was fighting and spit on E3 while taking R1 to the bathroom to provide incontinence care. Documentation includes that R1 was "very wet" and didn't like when E3 pulled R1's pants down. Documentation includes that another caregiver came in and that E3 told the caregiver she needed help. Further documentation includes that R1 spit on E3 and that E3 told R1 that wasn't nice to do. Further documentation is that another caregiver came into the room and E3 states "I'm going to walk away cause I don't like spitting."</p> <p>E4's written statement includes documentation that the incident occurred on 07-22-2024. The statement includes documentation that she was helping another staff person toilet a resident and could hear yelling on the other side of the wall. Documentation includes that E4 walked to the next room to see what was going on and that when she opened the door she saw R1 standing, holding onto E5 with E3 standing over R1. Documentation includes that E3 then walked past E4 while saying "I got to get out of here because I'm gonna do something to her." The statement includes documentation that E4 reported what happened to E6, Licensed Practical Nurse.</p> <p>E5's written statement includes documentation that the the incident occurred on 07-22-2024 about 1:45pm to 1:50pm. The statement includes documentation that she was in a bathroom with a</p>	A6000		

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A6000	<p>Continued From page 3</p> <p>resident and heard screaming through the wall in the next bathroom. E5 went to the other bathroom to see what was going on. Documentation includes that R1 and E3 were in the bathroom and that E3 was arguing with R1 because R1 didn't want her pants pulled down. Documentation includes that E5 tried having E3 step away so that she could try to calm R1 down and that E3 continued to argue with R1 and E5. Documentation includes that R1 got "worked up and shaky." E5 asked E3 to step away so E5 could get R1 calmed down and that E3 continued to "hover over (R1.)" R1 turned and spit in E3's face. "(E3) had ahold of under (R1's) arm and after (R1) spit at her, (E3) shoved her arm aggressively and said 'We do not spit on people. If you do that again Imma have to do something back.'" Documentation includes that E5 put her arm between E3 and R1 and asked E3 again to step back. E4 came into the room and asked what was going on; then E3 stormed past E4 and E5 saying, "I gotta get out of here before I do something back." Documentation includes that E3 disappeared until 2:00pm when it was time to do rounds.</p> <p>E3's 07-29-2024 Corrective Discipline Form contains documentation tha E3 received a written warning with a description of the issue as, "On 07/22/2024, employee was reported to be in shower room with resident, (R1,) when resident was frustrated about getting changed. Employee made comment, "That could make someone do something, I gotta go," after being spit on by resident and removed herself from the shower room, leaving resident with two other caregivers." Documentation of the violation of work rules is, "Making a comment about possible abuse to a resident." Documentation of the corrective action taken is, "Dementia care training on Relias, 6</p>	A6000		

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A6000	<p>Continued From page 4</p> <p>modules and certificates attached. The form is signed by E2, Licensed Practical Nurse, and E3, caregiver.</p> <p>On 08-19-2024, approximately 10:45am, E2 states that two caregivers came in and told her that there was an incident the day before in the restroom. They heard a resident yelling in the restroom about not wanting changed and one of them went to the bathroom to help calm the resident down. E2 states that statements were gotten from all staff involved, that the resident had no recollection of the event, and that the caregiver was immediately suspended and sent home pending investigation. E2 states that there were no findings and the caregiver returned to work.</p> <p>On 08-19-2024, approximately 1:45pm, E2 states that E4 and E5 came in the next morning, (07-23-2024,) at about 9:00am and told her about the incident the prior day involving R1.</p> <p>On 08-19-2024, approximately 1:50pm, E6 states that caregiver staff did tell him about the incident involving R1. E6 reviewed through his notes and the 24 hour report book stating that he doesn't see anything about the incident in the notes. E6 states that he remembers the incident but not the details, that he barely remembers what happened.</p> <p>On 08-19-2024, approximately 2:05pm, E2 states that an incident report was not done for R1 following the incident regarding the allegation. E2 states that she didn't realize they had to do an incident report with an allegation of abuse.</p> <p>On 08-19-2024, approximately 2:10pm, E4 states she wasn't sure of the time the incident occurred</p>	A6000		

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A6000	<p>Continued From page 5</p> <p>but that it was maybe 1 or 2 pm at the end of the day doing rounds. E4 states there are two restrooms next to each other separated by a wall and that she was in one bathroom helping a resident and that R1 and E3 were in the bathroom next door. E4 states she could hear yelling; E3 yelling she needed to put R1's pants on R1 and R1 yelling. E4 states she couldn't understand what R1 was yelling. E4 states that E5 went to help due to R1 yelling. E4 states that when she finished helping with her resident that she went to the bathroom next door and had just got to the door when E3 rushed past her saying she had to get out before doing something. E4 states that she just saw the "aftermath" and heard the yelling but didn't make alot out of what was said. E4 states that E5 told her E3 hit R1. E4 states that she told E6 about the incident right afterwards because hospice came in to check on R1. E4 also states that E6 got the residents mixed up.</p> <p>On 08-20-2024, approximately 11:05am, E5 states the incident occurred at the end of their shift about 1:40pm or 1:45pm on 07-22-2024. E5 states she was in the first bathroom with a trainee and heard screaming through the walls. E5 states that she went to the bathroom next door and saw E3 yank down R1's pants and that R1 was trying to hold them up. E5 states that R1 is blind so she tried to explain the process to R1 and calm R1 down. E5 states that E3 called R1 an animal and that R1 spit on E3. E5 continued stating that E3 pushed R1's arm upwards and that she told E3 to leave the situation and that as E3 was walking out that E3 said she needed to leave before she does something back. E5 states that E3 left and they don't know where she went but that E3 came back at about 2:05pm. E5 states she doesn't remember E3 cursing at R1</p>	A6000		
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A6000	<p>Continued From page 6</p> <p>and that E3 didn't hit R1 but just pushed R1's hand up and out of the way. E5 states that E4 did tell E6, the nurse, and that E4 also told R1's hospice nurse who then got R1's vital signs. E5 states she doesn't think the hospice nurse did anything else with R1 but she isn't sure. E5 states that when E4 reported the incident that it was time to leave work for the day.</p> <p>The establishment's 11-01-2014 (revised 03-10-2023) Resident Abuse and Neglect policy contains documentation that abuse is defined as "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, it will be assumed that the abuse caused physical harm, pain, or mental anguish." Mental abuse is defined as "any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing." Physical abuse is defined as "Any willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes but is not limited to striking with or without an object, slapping, kicking, pinching, choking, grabbing, shoving, or prodding..." The policy also includes documentation that alleged abuse will be immediately reported by the person who witnessed it, to the supervisor on duty or the Administrator. The same policy includes documentation that an incident report will be completed. Further documentation includes that if the resident is unable to understand or participate in an interview that a statement to that effect will be documented on an interview form.</p>	A6000		

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A6000	Continued From page 7 The policy includes documentation that a description of any alleged injury will be documented in the resident's record, and that the documentation should be specific.	A6000		
A7000	<p>Secton 295.7000 Resident Records</p> <p>This Regulation is not met as evidenced by: Type 3 Violation</p> <p>Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 9) Notation of known accidents, incidents or injuries;</p> <p>Based on record review and interview, the establishment failed to ensure R1's record contains documentation of an abuse allegation made on 07-22-2024.</p> <p>R1 was admitted to the establishment on 02-25-2022. R1's diagnoses include major neurocognitive deficit.</p> <p>R1's 07-24-2024 service plan includes documentation that R1 will be assisted with behavior management as needed to help decrease anxiety and agitation. The same service plan also includes documentation that R1 requires total assistance with transfers, dressing, and toileting. The service plan includes documentation that R1 requires hospice services.</p> <p>R1's 02-25-2022 Mini Mental Status Exam includes documentation that R1's score is 21 out of 30.</p>	A7000		

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A7000	<p>Continued From page 8</p> <p>R1's 02-25-2022 Global Deterioration Scale includes documentation that R1's score is 3.</p> <p>R1's July and August 2024 observation notes were reviewed. No observations notes were noted for 07-16-2024 through 07-24-2024.</p> <p>The establishment's investigation into the 07-22-2024 allegation were reviewed.</p> <p>The establishment's 07-22-2024 Report of Incident includes documentation that "Staff reported to nurse that employee and resident were in shower room and they heard hollering so checked on resident. Resident was upset about staff member trying to change her and did not want to get changed at this time. Staff member got frustrated with resident and tried to change her anyway. Resident then spit on staff member and staff member said, "you do that again and I'm going to have to do something back." Staff member the left the shower room and clocked out for the day. Staff member has been suspended pending investigation. Witness statements taken from both staff members who witnessed incident." The report also includes documentation that the resident is R1. The report does not include any staff member names or the time the incident occurred.</p> <p>The establishment's investigation includes staff member statements from three staff, E3, E4, and E5; all caregivers.</p> <p>E3's written statement includes documentation of the 07-22-2024 incident. The statement includes documentation that the incident involved R1. Further documentation is that R1 was fighting and spit on E3 while taking R1 to the bathroom to</p>	A7000		

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A7000	<p>Continued From page 9</p> <p>provide incontinence care. Documentation includes that R1 was "very wet" and didn't like when E3 pulled R1's pants down. Documentation includes that another caregiver came in and that E3 told the caregiver she needed help. Further documentation includes that R1 spit on E3 and that E3 told R1 that wasn't nice to do. Further documentation is that another caregiver came into the room and E3 states "I'm going to walk away cause I don't like spitting."</p> <p>E4's written statement includes documentation that the incident occurred on 07-22-2024. The statement includes documentation that she was helping another staff person toilet a resident and could hear yelling on the other side of the wall. Documentation includes that E4 walked to the next room to see what was going on and that when she opened the door she saw R1 standing, holding onto E5 with E3 standing over R1. Documentation includes that E3 then walked past E4 while saying "I got to get out of here because I'm gonna do something to her." The statement includes documentation that E4 reported what happened to E6, Licensed Practical Nurse.</p> <p>E5's written statement includes documentation that the the incident occurred on 07-22-2024 about 1:45pm to 1:50pm. The statement includes documentation that she was in a bathroom with a resident and heard screaming through the wall in the next bathroom. E5 went to the other bathroom to see what was going on. Documentation includes that R1 and E3 were in the bathroom and that E3 was arguing with R1 because R1 didn't want her pants pulled down. Documentation includes that E5 tried having E3 step away so that she could try to calm R1 down and that E3 continued to argue with R1 and E5. Documentation includes that R1 got "worked up</p>	A7000		

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A7000	<p>Continued From page 10</p> <p>and shaky." E5 asked E3 to step away so E5 could get R1 calmed down and that E3 continued to "hover over (R1)." R1 turned and spit in E3's face. "(E3) had ahold of under (R1's) arm and after (R1) spit at her, (E3) shoved her arm aggressively and said 'We do not spit on people. If you do that again Imma have to do something back.'" Documentation includes that E5 put her arm between E3 and R1 and asked E3 again to step back. E4 came into the room and asked what was going on; then E3 stormed past E4 and E5 saying, "I gotta get out of here before I do something back." Documentation includes that E3 disappeared until 2:00pm when it was time to do rounds.</p> <p>E3's 07-29-2024 Corrective Discipline Form contains documentation tha E3 received a written warning with a description of the issue as, "On 07/22/2024, employee was reported to be in shower room with resident, (R1,) when resident was frustrated about getting changed. Employee made comment, "That could make someone do something, I gotta go," after being spit on by resident and removed herself from the shower room, leaving resident with two other caregivers." Documentation of the violation of work rules is, "Making a comment about possible abuse to a resident." Documentation of the corrective action taken is, "Dementia care training on Relias, 6 modules and certificates attached. The form is signed by E2, Licensed Practical Nurse, and E3, caregiver.</p> <p>On 08-19-2024, approximately 10:45am, E2 states that two caregivers came in and told her that there was and incident the day before in the restroom. They heard a resident yelling in the restroom about not wanting changed and one of them went to the bathroom to help calm the</p>	A7000		

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A7000	<p>Continued From page 11</p> <p>resident down. E2 states that statements were gotten from all staff involved, that the resident had no recollection of the event, and that the caregiver was immediately suspended and sent home pending investigation. E2 states that there were no findings and the caregiver returned to work.</p> <p>On 08-19-2024, approximately 1:45pm, E2 states that E4 and E5 came in the next morning, (07-23-2024,) at about 9:00am and told her about the incident the prior day involving R1.</p> <p>On 08-19-2024, approximately 1:50pm, E6 states that caregiver staff did tell him about the incident involving R1. E6 reviewed through his notes and the 24 hour report book stating that he doesn't see anything about the incident in the notes. E6 states that he remembers the incident but not the details, that he barely remembers what happened.</p> <p>On 08-19-2024, approximately 2:05pm, E2 states that an incident report was not done for R1 following the incident regarding the allegation. E2 states that she didn't realize they had to do an incident report with an allegation of abuse.</p> <p>On 08-19-2024, approximately 2:10pm, E4 states she wasn't sure of the time the incident occurred but that it was maybe 1 or 2 pm at the end of the day doing rounds. E4 states there are two restrooms next to each other separated by a wall and that she was in one bathroom helping a resident and that R1 and E3 were in the bathroom next door. E4 states she could hear yelling; E3 yelling she needed to put R1's pants on R1 and R1 yelling. E4 states she couldn't understand what R1 was yelling. E4 states that E5 went to help due to R1 yelling. E4 states that</p>	A7000		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2024
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NAME OF PROVIDER OR SUPPLIER AMBER GLEN ALZHEIMER'S SCC	STREET ADDRESS, CITY, STATE, ZIP CODE 1704 EAST AMBER LN URBANA, IL 61802
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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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A7000	<p>Continued From page 12</p> <p>when she finished helping with her resident that she went to the bathroom next door and had just got to the door when E3 rushed past her saying she had to get out before doing something. E4 states that she just saw the "aftermath" and heard the yelling but didn't make alot out of what was said. E4 states that E5 told her E3 hit R1. E4 states that she told E6 about the incident right afterwards because hospice came in to check on R1. E4 also states that E6 got the residents mixed up.</p> <p>On 08-20-2024, approximately 11:05am, E5 states the incident occurred at the end of their shift about 1:40pm or 1:45pm on 07-22-2024. E5 states she was in the first bathroom with a trainee and heard screaming through the walls. E5 states that she went to the bathroom next door and saw E3 yank down R1's pants and that R1 was trying to hold them up. E5 states that R1 is blind so she tried to explain the process to R1 and calm R1 down. E5 states that E3 called R1 an animal and that R1 spit on E3. E5 continued stating that E3 pushed R1's arm upwards and that she told E3 to leave the situation and that as E3 was walking out that E3 said she needed to leave before she does something back. E5 states that E3 left and they don't know where she went but that E3 came back at about 2:05pm. E5 states she doesn't remember E3 cursing at R1 and that E3 didn't hit R1 but just pushed R1's hand up and out of the way. E5 states that E4 did tell E6, the nurse, and that E4 also told R1's hospice nurse who then got R1's vital signs. E5 states she doesn't think the hospice nurse did anything else with R1 but she isn't sure. E5 states that when E4 reported the incident that it was time to leave work for the day.</p> <p>The establishment's 11-01-2014 (revised</p>	A7000		
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Illinois Department of Public Health

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NAME OF PROVIDER OR SUPPLIER AMBER GLEN ALZHEIMER'S SCC		STREET ADDRESS, CITY, STATE, ZIP CODE 1704 EAST AMBER LN URBANA, IL 61802		
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A7000	Continued From page 13 03-10-2023) Resident Abuse and Neglect policy contains documentation that abuse is defined as "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, it will be assumed that the abuse caused physical harm, pain, or mental anguish." Mental abuse is defined as "any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing." Physical abuse is defined as "Any willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes but is not limited to striking with or without an object, slapping, kicking, pinching, choking, grabbing, shoving, or prodding..." The policy also includes documentation that alleged abuse will be immediately reported by the person who witnessed it, to the supervisor on duty or the Administrator. The same policy includes documentation that an incident report will be completed. Further documentation includes that if the resident is unable to understand or participate in an interview that a statement to that effect will be documented on an interview form. The policy includes documentation that a description of any alleged injury will be documented in the resident's record, and that the documentation should be specific.	A7000		