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ASPEN CREEK OF TROY II	1926 SRA BRADLEY SMITH DRIVE TROY, IL 62294

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A 000	Initial Comment Facility Reported Incident to 11/6/25 IL198700- Violations cited: 295.2000 c)1) 295.6000 a)1)13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 2 Violation Section 295.2000 Residency Requirements c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; Based on interview and record review, the Establishment failed to ensure Residency Requirements were met for R1. This failure creates a substantial probability of harm/injury to residents. Findings include: The Establishment's Illinois Department of Public Health Incident Notification documents on 11/6/25, R1 "suddenly turned toward (R2) and put his left arm around her neck". It further document R1 had just returned to the establishment on 11/5/25 after being admitted to the hospital for aggression toward staff. R1's Facesheet dated 11/16/25 document R1 has a diagnosis of Dementia with behavioral	A2000		

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A2000	Continued From page 1	A2000		

disturbance.

R1's Physician's Certification signed 10/15/25 documents, "Residency Condition and Limitations: Must pose no serious threat to anyone including self."

R1's Progress Notes dated 10/15/25 documents R1 was admitted to the facility from an ER at 12:00 PM. R1's Progress Notes continue to document at 3:15 PM on 10/15/25 R1 was being mildly aggressive with two staff members, by grabbing their arms. During this time, R1 entered room another resident's room, picked up a fan and hit the window with it, breaking the glass in the window.

R1's Progress Notes dated 10/17/25 documents R1 became "extremely aggressive, hitting, grabbing, throwing walker at multiple staff." R1's Progress Notes continue to document, "Res (Resident) walked up to nurse without warning or provocation, grabbed her by neck, choking her and pushed her up against the couch. He also hit her in her legs with a chair and grabbed her arm, attempting to make her fall over. POA (Power of Attorney) notified that res is a harm to himself and to others." R1 was transferred to the local ER for medical clearance prior to seeking treatment at a behavioral health facility.

R1's Progress Notes dated 11/5/25 documents R1 returned to the facility and placed on 1:1 supervision "until deemed to have less frequent aggression".

R1's Progress Notes dated 11/6/25 document, "Res left room with 1:1 staff. He pulled his pants down in the hallway. sitter tried to help him pull them up. He became agitated and pushed her

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A2000	Continued From page 2	A2000		

against the wall and put his hands around her neck. He then entered another res room and used her bathroom. He then entered another res room, as nurse tried to redirect him, he put his hands around her neck."

R1's Progress Notes dated 11/6/25 at 9 PM document, "Res was in d.r (dining room) placing chairs at table with 1:1 sitter present. He suddenly lunged at another res and wrapped his left arm around her head and neck. He was immediately redirected but remained agitated and physically aggressive to staff."

R1's Progress Notes dated 11/15/25 at 2:14 PM document staff reported R1 was chasing staff around the building looking for scissors. R1 was observed chasing staff with a wheelchair and shoving it at them attempting to hit them.

R1's Progress Notes dated 11/16/25 document R1 grabbed one staff members by the arm and threw his walker at another. R1's Progress Notes continue to document R1 was sent to the local ER due to recent increased agitation.

On 11/26/25 at 11:45 PM, E2, Licensed Practical Nurse stated, "Our other nurse just quit. We had a combative guy here and she was scared of him. He was a big guy. We were all scared of him, but he is gone now."

On 11/26/25 at 12:15 PM, E4, Resident Aid, stated R1 was sent to the ER for behaviors. E4 stated a couple days after R1 arrived to the establishment, he choked the nurse, E6 and broke a window. E4 stated R1 was "sent out for a bit, but came back." E4 stated R1 "chased us around for 2 hours, looking for scissors. He found a pair of scissors and E5 had to struggle with him

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A2000	Continued From page 3	A2000		

to get them away from him."

On 11/26/25 at 12:30 PM, E5 stated R1 broke a window in room, was sent to the ER, but R1 came back to the establishment. E5 stated R1 also chased staff around with a wheelchair, trying to hit them with it. E5 stated R1 "put his hands around (E6's) neck" and almost stabbed E5 with scissors R1 found in the kitchen. E5 stated R1 was tall and scary. E5 stated staff had to take R3 into the office and lock the door because R3 was "freaked out" by R1. E5 one time it took 3 staff members to get R1 to release his grip on her wrist. E5 ended the interview stating, "Clearly, this wasn't the right facility for him."

On 11/26/2025 at 12:40, the window in room 13 was broken, but covered with a hard plastic covering.

On 11/26/25 at 12:55 PM, E2 stated E3 screened R1 at the hospital an hour and 45 minutes away. E2 stated R1 began having behaviors within the first 10 minutes of arriving at the establishment and "busted the window first thing". E2 stated R1's aggression came on unprovoked and the 1:1 supervision did not prevent R1's behaviors. E2 stated other residents, as well as staff, were afraid of R1. E2 stated she heard R1 choked E6 and put R2 in a "headlock". E2 stated, "He (R1) absolutely should not have been here (at establishment). There was a reason why he was in the ER for a while because no one else wanted to take him".

On 11/26/25 at 1 PM, E3 stated she had screened R1 at the hospital. E3 stated R1 was at the hospital because he had "an incident" while living in an Assisted Living facility prior. E3 stated R1's wife was a "trigger" for him and there was an

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A2000	Continued From page 4	A2000		

altercation, but she is not exactly sure what happened. E3 stated R1 had been "laying in the ER" for days.

On 11/26/25 at 2:00 PM, E1 stated R1 did put his arms around R2's neck very suddenly and E1 was aware R1 had chased staff looking for scissors, and at one point, had the scissors, but staff got them away from R1 "so he wouldn't hurt anyone". E1 stated R1 had been sent to the hospital for aggression and returned on 11/5/25 with 1:1 supervision. E1 stated R1 was sent back to the hospital is cannot accept him back because "he seems to react better in an institution environment". E1 stated residency requirements are based on the physician's certification. E1 stated she was aware R1's aggression "puts other residents at risk" so she notified the hospital they would need to seek other placement for R1.

On 11/26/25 at 3:44 PM, E1 stated R1 was sent to the local hospital on 10/17/25 because he choked the nurse. E1 stated he came back to the establishment on 11/5/25 but "maybe we should not have taken him back, but someone has to take care of him."

The Establishment's Contract documents, "A person will not be accepted for residency if they are a serious threat to themselves or others."

The Establishment's Resident Rights document, "Federal and State law guarantee certain basic rights to all residents of this facility. These rights include the residents right to: a dignified existence, to be treated with respect, kindness, and dignity" as well as be free from abuse.

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A6000	Continued From page 5	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 1 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:

1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;

13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

Based on interview and record review, the Establishment failed to ensure Resident Rights were respected by accepting an individual for residency (R1), whom was aggressive towards R2. . This failure creates a substantial probability of severe harm/injury to residents

Findings include:

The Establishment's Illinois Department of Public Health Incident Notification documents on 11/6/25, R1 "suddenly turned toward (R2) and put his left arm around her neck". It further document R1 had just returned to the establishment on

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A6000	Continued From page 6	A6000		

11/5/25 after being admitted to the hospital for aggression toward staff.

R2's Progress Notes dated 11/6/25 document, "Res (resident) standing in dining room when another res suddenly lunged at her and put his lf (left) arm around her neck and head."

R1's Facesheet dated 11/16/25 document R1 has a diagnosis of Dementia with behavioral disturbance.

R1's Physician's Certification signed 10/15/25 documents, "Residency Condition and Limitations: Must pose no serious threat to anyone including self."

R1's Progress Notes dated 10/15/25 documents R1 was admitted to the facility from an ER at 12:00 PM. R1's Progress Notes continue to document at 3:15 PM on 10/15/25 R1 was being mildly aggressive with two staff members, by grabbing their arms. During this time, R1 entered room another resident's room, picked up a fan and hit the window with it, breaking the glass in the window.

R1's Progress Notes dated 10/17/25 documents R1 became "extremely aggressive, hitting, grabbing, throwing walker at multiple staff." R1's Progress Notes continue to document, "Res walked up to nurse without warning or provocation, grabbed her by neck, choking her and pushed her up against the couch. He also hit her in her legs with a chair and grabbed her arm, attempting to make her fall over. POA (Power of Attorney) notified that res is a harm to himself and to others." R1 was transferred to the local ER for medical clearance prior to seeking treatment at a behavioral health facility.

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A6000	Continued From page 7 R1's Progress Notes dated 11/5/25 documents R1 returned to the facility and placed on 1:1 supervision "until deemed to have less frequent aggression". R1's Progress Notes dated 11/6/25 document, "Res left room with 1:1 staff. He pulled his pants down in the hallway. sitter tried to help him pull them up. He became agitated and pushed her against the wall and put his hands around her neck. He then entered another res room and used her bathroom. He then entered another res room, as nurse tried to redirect him, he put his hands around her neck." R1's Progress Notes dated 11/6/25 at 9 PM document, "Res was in d.r (dining room) placing chairs at table with 1:1 sitter present. He suddenly lunged at another res and wrapped his left arm around her head and neck. He was immediately redirected but remained agitated and physically aggressive to staff." R1's Progress Notes dated 11/15/25 at 2:14 PM document staff reported R1 was chasing staff around the building looking for scissors. R1 was observed chasing staff with a wheelchair and shoving it at them attempting to hit them. R1's Progress Notes dated 11/16/25 document R1 grabbed one staff members by the arm and threw his walker at another. R1's Progress Notes continue to document R1 was sent to the local ER due to recent increased agitation. On 11/26/25 at 11:45 PM, E2, Licensed Practical Nurse stated, "Our other nurse just quit. We had a combative guy here and she was scared of him. He was a big guy. We were all scared of him, but	A6000		

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he is gone now."

On 11/26/25 at 12:15 PM, E4, Resident Aid, stated R1 was sent to the ER for behaviors. E4 stated a couple days after R1 arrived to the establishment, he choked the nurse, E6 and broke a window. E4 stated R1 was "sent out for a bit, but came back." E4 stated R1 "chased us around for 2 hours, looking for scissors. He found a pair of scissors and E5 had to struggle with him to get them away from him."

On 11/26/25 at 12:30 PM, E5 stated R1 broke a window in room, was sent to the ER, but R1 came back to the establishment. E5 stated R1 also chased staff around with a wheelchair, trying to hit them with it. E5 stated R1 "put his hands around (E6's) neck" and almost stabbed E5 with scissors R1 found in the kitchen. E5 stated R1 was tall and scary. E5 stated staff had to take R3 into the office and lock the door because R3 was "freaked out" by R1. E5 one time it took 3 staff members to get R1 to release his grip on her wrist. E5 ended the interview stating, "Clearly, this wasn't the right facility for him."

On 11/26/2025 at 12:40, the window in room 13 was broken, but covered with a hard plastic covering.

On 11/26/25 at 12:55 PM, E2 stated E3 screened R1 at the hospital an hour and 45 minutes away. E2 stated R1 began having behaviors within the first 10 minutes of arriving at the establishment and "busted the window first thing". E2 stated R1's aggression came on unprovoked and the 1:1 supervision did not prevent R1's behaviors. E2 stated other residents, as well as staff, were afraid of R1. E2 stated she heard R1 choked E6 and put R2 in a "headlock". E2 stated, "He (R1)

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A6000	Continued From page 9	A6000		

absolutely should not have been here (at establishment). There was a reason why he was in the ER for a while because no one else wanted to take him".

On 11/26/25 at 1 PM, E3 stated she had screened R1 at the hospital. E3 stated R1 was at the hospital because he had "an incident" while living in an Assisted Living facility prior. E3 stated R1's wife was a "trigger" for him and there was an altercation, but she is not exactly sure what happened. E3 stated R1 had been "laying in the ER" for days.

On 11/26/25 at 2:00 PM, E1 stated R1 did put his arms around R2's neck very suddenly and E1 was aware R1 had chased staff looking for scissors, and at one point, had the scissors, but staff got them away from R1 "so he wouldn't hurt anyone". E1 stated R1 had been sent to the hospital for aggression and returned on 11/5/25 with 1:1 supervision. E1 stated R1 was sent back to the hospital is cannot accept him back because "he seems to react better in an institution environment". E1 stated residency requirements are based on the physician's certification. E1 stated she was aware R1's aggression "puts other residents at risk" so she notified the hospital they would need to seek other placement for R1.

On 11/26/25 at 3:44 PM, E1 stated R1 was sent to the local hospital on 10/17/25 because he choked the nurse. E1 stated he came back to the establishment on 11/5/25 but "maybe we should not have taken him back, but someone has to take care of him."

The Establishment's Contract documents, "A person will not be accepted for residency if they

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A6000	Continued From page 10 are a serious threat to themselves or others." The Establishment's Resident Rights document, "Federal and State law guarantee certain basic rights to all residents of this facility. These rights include the residents right to: a dignified existence, to be treated with respect, kindness, and dignity" as well as be free from abuse.	A6000		