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	IL6016489	A. BUILDING: _____ B. WING _____	C 04/22/2021

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ASBURY COURT NURSING & REHAB	1750 ELMHURST ROAD DES PLAINES, IL 60018

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S 000	Initial Comments Facility Reported Incident of March 8, 2021/IL131799	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a) b) 300.1210 d)3) 300.1830 a) 300.3210 f) g) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1830 Records Pertaining to Residents' Property

a)The facility shall maintain a record of any resident's belongings, including money, valuables and personal property, accepted by the facility for safekeeping. This record shall be initiated at the time of admission and shall be updated on an ongoing basis and made part of the resident's record.

Section 300.3210 General

f) The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories.

g) The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints.

This REQUIREMENT is not met as evidenced by:

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S9999	Continued From page 2 Based on interviews and record reviews, this facility failed to prevent misappropriation and exploitation of money by facility staff for one resident (R2) out of three residents reviewed for misappropriation of funds. This failure has resulted in R2 becoming isolated and withdrawn. Findings include: On 4/14/2021 at 12:40 pm, V11 (Business Office Manager) stated that R2 set up automatic withdrawal with R2's bank to pay for R2's stay at this facility. V11 stated that when corporate office went to withdraw money on 3/8/21, it was denied due to insufficient funds in R2's bank account. V11 stated that V11 spoke with R2 regarding funds and R2 informed V11 that R2's debit card had been stolen. V11 stated that V11 called R2's bank in the presence of R2. R2 gave permission for bank to speak with V11. V11 stated that the bank informed V11 and R2 that R2's account was closed due to insufficient funds too many times or due to not enough money in account to keep it open. R2 requested the last 10 transactions posted, R2 was not aware of any of these transactions. R2 requested the address listed on R2's bank account; R2 did not recognize the address. R2 informed V11 that R2 believes this related to wallet being stolen. V11 stated that the banker on the phone was not able to disclose any further transactions and gave R2 a phone number at the bank R2 could call for further information. V11 stated that R2 was overwhelmed and did not want to call the number that day. V11 stated that V11 did not have any further communication with R2 after that day. V11 is unaware if R2 ever called the phone number the bank gave R2. V11 stated that V11 informed V1 (Administrator) of the incident and	S9999		

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gave V1 the information gathered from the phone call with R2's bank.

On 4/14/2021 at 1:00 pm, V1 (Administrator) stated that V1 spoke with R2 upon notification by V11 (Business Office Manager) of concern regarding R2's funds. V1 stated that R2 informed V1 that R2 can't get access to R2's bank account. V1 stated that R2 informed V1 that R2 wanted to press charges against the former staff responsible. V1 stated that the local police department was notified of an allegation of misappropriation of R2's property. V1 stated that a police officer came to this facility to interview V1 and initiate a police report. V1 stated that on 3/14/21 a police detective came to this facility to interview R2. V1 stated that R2 informed V1 that police were not welcome here. R2 changed his mind and did not want to press charges against the former staff members. V1 stated that there is nothing else V1 can do if R2 does not want to press charges. V1 denied speaking with all residents currently residing in this facility and/or their families regarding their resident funds to determine if other resident(s) were affected as well. V1 acknowledged that V15 (former CNA) received a verbal warning on 10/8/2020 for exhibiting verbal aggression in a threatening manner with confrontational behavior towards a staff member. V1 acknowledged that on 11/10/2020 V15 was terminated for intimidating another staff member affecting resident care. When questioned regarding the possibility of V15 exhibiting the same inappropriate behaviors with residents, V1 did not respond. V1 stated that this facility does not have an inventory list of R2's belongings when R2 was admitted to this facility on 2/14/2020. V1 stated that this facility started inventorying resident belongings with new admissions starting in March 2021. V1

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acknowledged that it is unknown what belongings R2 had at the time of R2's admission to this facility in February 2020 as well as if any other belongings are missing. When questioned regarding this facility's plan to prevent future occurrence(s) of misappropriation of resident property, V1 stated that this facility is trying to have R2's social security funds deposited into a resident fund for R2 that will be managed by this facility. V1 stated that V1 does not recall if V2 (Social Services Director) was notified of the two allegations, 9/17/20 and 3/8/21, of misappropriation of property involving R2.

On 4/14/2021 at 1:05 pm, V12 (Executive Director of Senior Living) stated that on 3/8/21, V12 was notified by V11 (Business Office Manager) that R2's payment check had bounced. V12 stated that V11 informed V12 that V11 spoke with R2 regarding this matter and R2 did not know what was going on with R2's bank account. V12 stated that R2's bank account was closed by the outside bank due to insufficient funds. V12 stated that review of the past 10 transactions posted to R2's account noted money transfers to a person that R2 did not know. V12 stated that V12 spoke with R2 to see if R2 wanted to press charges, R2 was agreeable, and a police officer spoke with R2. V12 stated that about one week later a police detective came to the facility to speak with R2; R2 refused to speak with the detective. V12 stated that the name associated with the money transfers was V22 (former CNA/Certified Nurse Assistant) that worked at the senior living center attached to this facility. V12 stated that V22 (former CNA) worked for three days between 7/21/2020 and 7/31/2020 and then did not show up to work anymore. V12 stated that V15 (former CNA and relative of V22) worked on this facility's skilled nursing unit. V12 stated

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that V15 worked at this facility 7/9/2020 to 11/10/2020 when V15 was terminated due to insubordination with a supervisor. When questioned regarding the possibility of V15 exhibiting the same inappropriate behaviors with residents, V12 did not respond.

On 4/16/2021 at 3:00 pm, V2 (Social Services Director) stated that R2 is alert and oriented x3 and able to make needs known. V2 stated that V2 is responsible for completing cognitive status, mood interview, and behavior interview on each resident's comprehensive assessment (MDS/Minimum Data Set) upon admission, quarterly, annually, and with significant changes. V2 stated that even though V2 conducted the comprehensive assessment with R2 on 3/31, V2 was not aware R2's mood interview score increased/worsened to 18 out of 27. V2 stated that V2 was not involved with the investigation into the allegation of misappropriation of property involving R2 and would only get involved if V1 asks V2 to assist. V2 stated that V2 was recently made aware of the allegation of misappropriation of property involving R2 and former staff members that occurred in March 2021. V2 stated that V2 has not spoken with R2 because R2 was admitted to the local hospital prior to V2's knowledge of these allegations of misappropriation of property. V2 stated that V2 does not recall meeting with R2 after R2's first allegation of misappropriation of property involving R2's wallet and money missing last September. V2 stated that V2 did not observe any weight loss with R2. V2 acknowledged that R2's worsening mood score and weight loss could be related to the allegations of abuse.

On 4/21/2021 at 11:40 am, V21 (Activities Director Senior Living) stated that V21 was asked

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by V11 (Business Office Manager) to accompany V11 to speak with R2 regarding R2's funds. V21 stated that V21 has known R2 since R2 was admitted to the senior living center attached to this facility and has a good relationship with R2. V21 stated that V21 witnessed the telephone call between V11, R2, and R2's bank. V21 stated that V11 documented the past transactions posted to R2's bank account. V21 stated that the name attached to several transactions sounded familiar; the name was of V22 (former CNA) that worked at the senior living center. V21 stated that V21 did not speak with R2 after the telephone call with R2's bank.

Review of R2's medical record, notes R2 was admitted on 2/14/2020 with diagnoses including: Stage 4 kidney disease-on dialysis, diabetes, COVID-19 on 1/14/21, malignant neoplasm of kidney, depressive disorder, protein-calorie malnutrition, schizophrenia, insomnia, hyperlipidemia, anemia, anxiety disorder, and high blood pressure.

Review of R2's progress notes:
On 8/11/20, nurse noted R2 appears more depressed per nurse practitioner when rounded this morning. Psychiatric nurse practitioner notified. V18 NP (nurse practitioner) noted R2 with flat affect, unkempt, wet diaper and clothes noted, per V15 (former CNA), refused care this morning. Instructed V15 to offer care again.
On 9/17/20 at 8:34 am, R2 is refusing to go to dialysis. R2 is not even willing show the catheter site. Not giving any reason. Informed DON (Director of Nursing) and ADON (Assistant Director of Nursing). Informed outside dialysis center. Dialysis rescheduled for Saturday, 9/19/20. At 5:15pm, R2 stated that R2 could not find wallet and is missing $300. V15 worked on

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the same unit as R2 on 9/17/20 from 7:00am to 7:00pm.
On 9/18/20, R2 agreed to go to dialysis this coming Saturday, 9/19/20. V15 was not scheduled to work on 9/19/20.
On 10/8/20, V15 was present in this facility but per schedule, V15 was not scheduled to work that day. V15 exhibited unprofessional conduct towards coworkers as evidenced by verbal aggression in a threatening manner with confrontational behavior.
On 11/10/20, V15 CNA in verbal altercation with V14 RN (registered nurse) in front of residents, regarding putting R2's lunch away so other resident would not eat it while R2 was at dialysis.
On 11/28/20, V13 RD (registered dietitian) noted R2 has steadily weight loss since September (-7.7%, -23.2lbs). R2's weights: on 10/29/20, 285 pounds, on 9/5/20, 303 pounds.
On 12/31/20, V13 RD noted continued weight loss. R2's weight 277.7 pounds.
On 3/4/21, V13 RD noted continued weight loss. R2's weight 267.7 pounds.
On 3/8/21, R2 informed bank account closed due to insufficient funds.
On 4/1/21, R2 refused to go to dialysis today. R2 was verbally aggressive towards V3 (Clinical Director). R2 stated "Just leave me alone." R2 also refused breakfast and lunch.
On 4/6/21, R2 refused all care even after given education, R2 didn't eat any meals, all meals refused. Education given all the time, still insisting. Will continue to educate and redirect R2. R2 refused to go for dialysis, Writer educated about importance of dialysis, R2 still insisted. Asked R2, does R2 want to go for dialysis on Wednesday, refused. R2 ate 25% dinner, some medications refused.
On 4/12/21, R2 transported to local hospital for unstageable pressure ulcers on heels and

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S9999	Continued From page 8 cellulitis (skin infection) of left lower leg. As of 4/22/2021, R2 is still in the hospital. This surveyor attempted on 6 occasions during this survey to speak with R2 but was unsuccessful. R2's nurse at the hospital informed this surveyor that R2 is refusing to speak with anyone on the telephone as well as refusing in-person visits with anyone. Review of R2's BIMS (Brief Interview of Mental Status) score, dated 3/31/2021, notes R2's score is 14 out of 15. R2 is able to make needs known. Review of R2's MDS (Minimum Data Set), dated August 2020 to March 2021, notes on 8/6/20 R2's mood was 4 out of 27; on 9/12/20 R2's mood was 4 out of 27; on 10/8/20 R2's mood increased/worsened to 10 out of 27; on 1/4/21 R2's mood improved to 4 out of 27; and on 3/31/21 R2's mood increased/worsened to 18 out of 27. Review of R2's medical record does not note a care plan was initiated or updated related to R2's risk for abuse or allegation of misappropriation of resident property. Per whitepages.com, the address listed on R2's bank account is associated with V15 (former CNA). Review of this facility's abuse prevention policy, undated, notes this facility affirms the right of our residents to be free from abuse or misappropriation of property. This facility will prevent occurrences of abuse and misappropriation of property by: establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment,	S9999		

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S9999	Continued From page 9 identifying occurrences and patterns of potential mistreatment, immediately protecting residents involved in identified reports of possible abuse and misappropriation of property, implementing systems to promptly and aggressively investigate all reports and allegations of abuse and misappropriation of property, and making the necessary changes to prevent future occurrences. (B)	S9999		