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
	IL6004519	A. BUILDING: ______ B. WING ______	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATE SENIOR LIVING	16300 SOUTH LOUIS AVENUE SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation #2395644/IL161826 - No Deficiency #2395907/IL162138 - 330.4240 b) c) d)	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.4240b)c)d) Section 330.4240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) These requirements are NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to document and report a suspicious abuse incident and conduct a thorough investigation of an abuse allegation for one (R1) of three residents reviewed for abuse.	S9999	Attachment A Statement of Licensure Violations	

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Findings include:

R1 is an 81 year old, female, admitted in the facility on 04/01/2021 with diagnoses of Dementia and Hypertension.

On 10/03/23 at 11:30 AM, R1 was observed in the dining room, sitting in a wheelchair. R1 is alert, verbal but with confusion. R1 was asked about concerns related to any incident which caused bleeding in her mouth. She responded "They are wonderful, I am going to eat now. They are wonderful."

On 10/03/23 at 1:21 PM, V3 (Certified Nurse Aide, CNA) was asked regarding R1. V3 replied, "I don't remember the date but there was this time that I was calling her to go back to her room. Her hand was in her mouth, when I checked, there was bleeding in her upper lip. I asked her what happened, she said the bastard hit my mouth. She did not say who the bastard was. I reported it to V6 (Former Nurse Supervisor). It was investigated, I wrote a statement and gave it to V2 (Business Office Manager). They said nothing was found. It was V4 (CNA), and she still works in the facility. "

V6 was interviewed on 10/03/23 at 1:41 PM regarding R1's incident. V6 verbalized, "I am not sure about the date but probably December, 2022. I am not an employee of the facility anymore, I quit, it was just too much. That time, one CNA, V3, came to me the next morning. She said that R1 went to her saying that she got hit in the mouth by V4. I reported it to V1 (Executive Director). The following day, V3 was called and I had her come down to the office and was asked about the incident. She (V3) denied that she told me that the incident happened. Basically, she

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said that V4 did not do it. She (V3) kind of threw me under the bus that time because she denied the incident. So, V2 told her (V3) that she put everybody's lives on the line by telling that an incident happened and then not. She (V3) apologized, and she was very quiet. I asked her why she did that, and she did not respond to me. Then we went back upstairs. Upstairs, she was again saying that it did happen, but I just walked out. That time, I assessed R1 and her mouth was swollen. I took a picture and sent it to V1 and V1 said she is going to take care of it. I did not call the doctor. From the video that we watched; V4 was walking towards R1 very aggressively. We can't see R1 in the video completely. But we did not see her (V4) hitting R1 in the mouth."

Onn 10/03/23 at 2:36 PM V2 stated in an interview, that she was informed by V4 regarding allegations. V2 continued, "I did not do any reports, that is not my job. The nurse should be the one investigating. It is not my job."

On 10/03/23 at 2:19 PM, V4 stated in an interview, "I was aware of that allegation, roughly 2022. All I know was I was called at home that R1 made a statement that I did hit her. I don't know how R1 made that statement because she cannot identify people and has issues with memory. It was said that I hit her but when they went to do an assessment, nothing was found. I was suspended for one day."

According to V9 (Nurse Supervisor), facility has no abuse reports since last year.

A review of R1's progress notes from January 2022 to current showed no documentation of an incident related to bleeding and swelling in mouth. There was also no incident and investigation

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report on file regarding abuse allegation. Local state agency was not notified and there was no documentation that R1's responsible party was notified about incident.

On 10/04/23 at 1:15 PM, V1 was asked regarding incident involving R1 and V4. V1 stated, "V6 is supposed to assess and observe R1. V6 needed to report it to V9 also. I was home on vacation that time. The incident should have been documented and reported to local state agency. There was no documentation in the file and it was not reported to state agency. V6 should assess R1 and report it to me. I didn't get the report. I was on vacation if she did call me or notify me. I should have given her the directives to notify Supervisor and investigate the allegation."

Facility's policy titled "Abuse Prevention Program" dated 2-2017 documented in part but not limited to the following: Handout B -Abuse Prevention program Training: Staff Obligations to Prevent and Report Abuse, Neglect, Exploitation and Theft. Under the law and the facility's policy, every employee is obligated to report any incident or suspicion of abuse, neglect, exploitation or misappropriation to a department head or the administrator immediately. Keeping an observed incident of abuse to yourself or covering it up is as serious as the abuse itself. Any charge or accusation by a resident or family that there was abuse, neglect, exploitation or misappropriation must be reported to a department head and the administrator, so it can be properly investigated, even if it is obvious that the resident is incorrect or mistaken. Do not make the decision about an accusation yourself.

(B)

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