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
	IL6009856	A. BUILDING: _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S 000	Initial Comments Complaint Investigation 2382739; IL00158272	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.1210 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.	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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S9999	Continued From page 1 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 regulations were not met as evidenced by: Based on interview and record review, facility failed to affirm the right of the resident to be free from physical abuse. This deficient practice affected 1 (R2) of 5 residents reviewed for abuse. This failure resulted in R2, a resident with dementia who resides on a secured dementia unit to be slapped on the cheek by a certified nursing assistant. Findings Include: Facility Initial Incident Report (dated 04/03/2023) states: It was reported to the administrator on 04/03/2023, that R2 had a physical altercation with a certified nursing assistant. Nurse immediately intervened and separated R2 and the certified nursing assistant. Certified nursing assistant was immediately suspended, pending investigation. Family and physician notified. Investigation initiated. Final report to follow. R2's Face Sheet documents resident is a 70-year-old with diagnoses including but not limited to: Alzheimer's disease, unspecified encephalopathy, unspecified, type 2 diabetes mellitus with other specified complication, peripheral vascular disease, unspecified, generalized anxiety disorder, ischemic cardiomyopathy, delirium due to known physiological condition, cognitive communication	S9999		

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deficit, hyperlipidemia, unspecified, dementia in other diseases classified elsewhere.

Care plan (dated 03/09/2023) documents that R2 has a diagnosis of dementia.
Care plan (dated 03/15/2023) documents that R2s at risk for abuse related to: Has a dx of dementia.

On 04/08/2023 at 8:30am, surveyor observed R2 sitting in the dining room on the 4th floor secured dementia unit. When asked by surveyor if resident remembers being slapped by a staff member, resident replies, "No." Surveyor asked if R2 felt comfortable and safe in R2's environment, R2 replied, "Yes." R2 stated something else in additional, however, surveyor was not able to comprehend R2's speech, due to R2's diagnosis of Alzheimer's/Dementia.

On 04/08/2023 at 8:41am, V5 (licensed practical nurse) stated, R2 never reported that R2 was handled in a rough manner and R2 never reported that R2 was slapped by a staff member. R2 is confused and does not have the cognitive capacity to remember. R2 has dementia and is cognitively impaired and unable to verbalize needs and not able to report such an occurrence."

On 04/08/2023 at 1:20pm V1(administrator) stated, "On 04/03/2023, V12 (licensed practical nurse) reported to me that V13 (certified nursing assistant) slapped R2 on the face. V12 had V13 leave the room right away. We sent V13 home and we started the abuse investigation. According to V11(certified nursing assistant), R2 had a fall prior to this incident and R2 was being combative. V11 told me that V11 called another CNA, V13, into the room for assistant because R2 was on

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the floor. V11 stated that as V11 and V13 were assisting the resident, the resident was waiving and raising R2's arms in a combative way and attempted to hit V13, and V13 was trying to block R2 from hitting V13 and somehow during the process of V13 attempting to block R2's hands, V13's hands touched R2's face. V11 stated that V13 was not trying to hit the resident but was only trying to protect herself from R2's hands. I was told by V11 that V13's hands made contact on R2's cheek. I have not completed the full investigation yet and have not submitted my final report, but V11 did say that V13's hand made contact with the resident's face. I am the abuse prevention coordinator. The abuse prevention training is on the annual training calendar. All the staff that work in the facility receive the abuse prevention training. Residents have the right to be free from abuse and live in a home like environment.

On 04/08/2023 at 7:45pm, V12 (Licensed practical nurse) stated, "On 04/03/2023, between 5:30am and 5:45am, I was working on the 4th floor passing mediation, and I noticed V11 (certified nursing assistant) coming out of R2's room and walking toward V13 (certified nursing assistant) and both V11 and V13 walked back into R2's room. I decided to follow them, and I stood into R2's doorway. I saw R2 on the floor and V11 and V13 placed R2 back in bed. While R2 was in bed, I saw R2 raise his arm up and all of a sudden, I saw V13 slapped R2 on the left side of the cheek. V13 slapped R2 like it was nothing. V13 did not hesitate and just slapped R2, almost like she has done it before, and I say this because of how comfortable V13 felt slapping the resident. I intervened and told V11 and V13 to leave R2 alone because he is agitated. When V13 came out of R2's room, I asked her why she

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slapped the resident and V13 said that she did not. I said to V13, "You just slapped the s*** out of R2 like it was nothing, and V13 denied it. I informed the supervisor on duty, and I sent V13 home. I could not believe how V13 just slapped the resident without hesitation and how comfortable V13 felt doing so. I felt so bad for the resident, and I reported this incident immediately."

On 04/09/2023 at 8:07pm, V13 (certified nursing assistant) stated," On 04/03/2023, V11 (certified nursing assistant) asked for assistance because R2 well and he was being combative. I know R2, and I took care of R2 many times and he is combative. R2 has hit me several times before, so I knew he was being combative. I went to R2's room along with V11, and R2 was laying on the floor. As I was assisting V11 with placing R2 back to bed, R2 hit me in my stomach. R2 was placed in bed, and he was being combative. I did slap R2. I never hit R2. V11 was present in R2's room with me the entire time and at some point V11 turned her face to grab a diaper. The nurse was standing there and told us to leave the resident alone. As I left R2's room, V12 (licensed practical nurse) said to me, "Why did you just slap the resident." I told V12 that I did not hit R2, but the nurse kept saying to me that I did slap R2 and that I was going to lose my license. I denied slapping R2. V12 sent me home and I was suspended. I did not abuse any resident. I am currently suspended until they investigate the incident."

On 04/09/2023 at 9:54, V11 (certified nursing assistant) stated, " R2 is resistant to care often and becomes combative. On 04/03/2023. R2 was on the floor, and I asked V13 (CNA) to assist me with placing R2 back to bed because R2 has hit

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me before. V13 and I went to the R2's room and V13 popped his cheek. V13 said to R2, let go and slapped R2's cheeks, I guess V13 was trying to play around with the resident to get him up. I did witness V13 slap the resident's cheeks and I don't think that she was intentionally trying to harm him or abuse him. That's how V13 plays with the residents. I have been her do this several times to other residents and other nurses seen her do this too. This was not the first time that V13 has popped a resident's cheek. V13 did not slap R2 hard. R2 was already on the bed when V13 slapped his cheeks, and we were trying to clean the resident and get him dressed. After V13 slapped the resident's cheeks, the R2 pushed V13 away, and did not want V13 to touch him. Some days the resident will allow us to provide care and other days he is resistant and hits the staff. The nurse was in the room when it happened and saw this. When V13 slapped the resident's cheek she said to the resident "It's time to get up now," trying to be playful and V13 was not trying to be harm R2. When V13 popped R2's cheek, it probably did hurt R2. I'm sure it hurt the resident. I would not want anybody to slap me like that. I would not want anybody to touch me like that. I was shocked that V13 did that. The nurse was in there and saw this, and I did not want to say anything since the nurse saw this, so I waited for the nurse to intervene. The nurse said to leave the resident along. V13 should not have done that. V13 definitely should not have done that at all, and I was shocked. I did receive training in the facility on abuse prevention."

Resident Rights Policy (undated) states: Resident have the right to be free from physical, sexual, mental, verbal and financial abuse.

"Interdisciplinary Team Note (dated 04/03/2023)

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S9999	Continued From page 6 documents, "Writer spoke with resident's daughter, to inform her of altercation with staff member. Writer also informed of facility response to altercation and investigation. Daughter voiced appreciation for the update and had no questions at this time." (B)	S9999		