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	IL6000046	A. BUILDING: _____ B. WING _____	03/27/2024

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ADDOLORATA VILLA	555 MCHENRY ROAD WHEELING, IL 60090

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S 000	Initial Comments Annual Licensure Survey Facility Reported Incident of 12/11/2023/IL168480 Facility Reported Incident of 3/02/2024/IL170720 Facility Reported Incident of 2/22/2024/IL170413 Facility Reported Incident of 1/23/2024/IL169505 Facility Reported Incident of 1/17/2024/IL169273	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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	S9999		

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S9999	Continued From page 1	S9999		

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.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

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 requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to protect the residents' right to be free from physical, verbal, and mental abuse by an employee, and failed to follow its abuse policy related to prevention, identification of abuse. These failures affected one (R55) of six residents in the sample of 37 residents reviewed for abuse. These failures resulted in R55 feeling angry, uncomfortable, and humiliated by the employees physical and verbal actions towards R55.

Findings include:

R55 is a 55-year-old female who has resided at the facility since 6/1/2022 with past medical history including, but not limited to Friederichs

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S9999	Continued From page 2	S9999		

ataxia, age-related osteoporosis without current pathological fracture, vitamin D deficiency, thoracogenic scoliosis, thoracic region, overactive bladder, pain in right leg, pain in left hip.

Minimum Data Set (MDS) assessment dated November 30, 2023, section C (Cognitive) documented R55 has a BIMs (Brief Interview for mental Status) score of 13, section GG (functional abilities and goals) of the same assessment indicated that R55 requires substantial/maximal assistance from staff for most activities of daily living (ADLS).

Abuse and neglect screening for R55 dated 6/15/2023 scored her as low risk for abuse, screening dated 12/15/2023 scored resident as low risk and no history of abuse. R55 does not have any care plan or interventions for abuse.

Facility reported incident (initial) dated 12/11/2023 documented R55 reported to her Nurse and the Administrator that a CNA made inappropriate comments to her and slapped her. She could not recall the exact times, but it was over the course of the last few months. The perpetrator was put on administrative leave pending investigation.

The final report documented that V1 (Administrator) interviewed R55 on 12/11/2023 and resident stated that V8 (CNA) hit her on her behind and called her a fat ass. Resident stated that the last time V8 hit her on the behind was last Thursday, he used to do it more often, it quit for a while and then started again. R55 added that when V8 called her a fat ass, she said to him, no I am not a fat ass. R55 also reported to V1 that one time she was coming out of the shower with V8, and he said, "I was going to kiss you back there, and R55 said no", R55 added that V8

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S9999	Continued From page 3	S9999		

went on to make some kissing noises as they were walking down the hall. On 12/13/2023, V1 received an email from R55's sister indicating that she spoke to R55 last night and she reported that after drying her in the shower, V8 will touch her breast to make sure there was no soap left. V1 followed up with R55 the same day and she stated that while showering, V8 will put his bare hand under her armpit and under her breast to make sure the soap was all gone. R55 added that he made her feel uncomfortable. On 12/12/2023, V1 interviewed V8 who admitted to patting R55 on her bottom, did not consider it inappropriate because R55 wears a sanitary napkin inside her pull up and he pats the area to make sure everything is in its place. V8 denied calling R55 a fat ass but said that he groaned after transferring resident from bed to wheelchair, R55 asked him why he groaned, and he said to resident, "your weight is ½ of mine, so you are not a light weight, your weight is heavy." V8 denied telling resident that he was going to kiss her or making any kissing noises.

On 3/19/2024 at 11:10AM, R55 was observed in her room, awake, alert and oriented and stated that she is doing okay. Surveyor asked the resident about the incident that happened with a staff in December of 2023. R55 said, you mean the guy? Surveyor said, yes. R55 said that this staff will pat her on her bottom after changing her incontinence brief, and she does not think that he should be doing that. Surveyor asked resident how that made her feel. R55 said, it makes her angry, it is not appropriate for him to be doing that. R55 also said, "The staff member identified as V8 called her a 'fat ass' and that was wrong of him, no one should be addressed like that". R55 reported the incident to a nurse because it makes her feel uncomfortable. R55 added, she has not

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S9999	Continued From page 4	S9999		

seen the staff recently, she thinks he got another job, she has not had any issues with any other residents or staff.

On 03/20/24 12:04 PM, V1 (Administrator) said that she investigated the abuse allegation for R55, resident is alert and oriented X3 and has never made any abuse allegation towards any staff or resident. V1 interviewed the resident who told her that staff (V8) called her a fat ass, pats her on her bottom after changing her incontinence brief and touched her breast during showering. V8 was suspended during the investigation, and he did not return to the facility because he was terminated. V1 said that she did not substantiate abuse because the staff (V8) was able to explain the patting on resident's bottom, it is not the appropriate thing to do because it could be interpreted as uncomfortable for the resident, staff are not supposed to make residents uncomfortable. V1 said that she did not consider this abuse, but staff was terminated due to customer service, he could have used better judgement when providing care, and she felt it was better to part ways.

On 03/20/24 02:10PM, V4 (Executive Director) said, residents are screened for abuse risk upon admission and every 6 months. Those at risk will be identified and referred to nursing and social worker for follow-up. Those identified at risk will have a care plan, at risk residents are those with psych issues, aggressive behavior, history of abuse and substance abuse. Dependent residents may potentially be at risk for abuse, but they don't have an abuse care plan. If there is an allegation of abuse and it is not substantiated, the resident will not have a care plan because no abuse occurred. The Administrator investigates all abuse and does a good job, if she said abuse

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S9999	Continued From page 5	S9999		

did not occur, then there is no abuse.

On 03/20/24 02:38 PM, V30 (LPN) said, she is familiar with R55, has worked with her since she was admitted, she was the nurse that the resident reported the abuse to. She came to work on second shift and the resident told her that she wanted to speak to her. R55 said that it was private and asked her to close the door. R55 said to V30, "He was here today and helped another staff get me up". V30 asked resident who is he and she mentioned V8 and said that V8 called her a fat ass. V30 immediately called V1 who happened to be on grounds, she came up to the floor and spoke to the resident. V30 stated that she reported the incident immediately to V1 because she considers it abuse.

Abuse policy revised /7/2018 states in part that the facility affirms that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including, but not limited to community staff, other residents, consultants, contractor, etc. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

Under prevention of abuse, neglect and exploitation, the policy states 1. Assess, monitor, and develop appropriate plan of care for residents with needs and behaviors which might lead to conflict or neglect, such as residents with history of aggressive behavior, residents with communication disorders and those that require heavy nursing care and/or are totally dependent on staff.

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S9999	Continued From page 6	S9999		

Facility's policy titled, "Abuse, Neglect and Exploitation" dated 03-07-2018 documented in part but not limited to the following:
Policy: (Name of Ministries) affirms that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but it not limited to: freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to: community staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends or other individuals.
Purpose: To ensure that a comprehensive program exists in all aspects of community operations involving the prevention, identification, reporting, and investigation of abuse.
Prevention of Abuse, Neglect and Exploitation
1. The community will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents:
k. Supervise staff to identify inappropriate behaviors, such as using derogatory language, rough handling, or ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their beds.
l. Assess, monitor and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communication disorders, and those that require heavy nursing care and/or are totally dependent on staff

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S9999	Continued From page 7	S9999		

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