STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000046	A. BUILDING: _____ B. WING _____	C 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDOLORATA VILLA	555 MCHENRY ROAD WHEELING, IL 60090

(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 2195748/IL136938	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (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 residents from abuse and neglect by not providing timely incontinence care and by staff speaking to residents in a demeaning manner. This failure applied to two (R1 and R2) out of three residents reviewed for abuse and resulted in R1 and R2 experiencing mental duress and humiliation after having to endure sitting in their own urine and feces for extended periods of time without toileting assistance from staff. Findings include: 1. R1 is an alert and oriented 65 year old with diagnoses listed in part but not limited to: multiple sclerosis, muscle weakness and difficulty in walking. Care plan with goal date of 9/29/21 shows R1 requiring extensive assistance with toileting assist from 1-2 people. On 8/14/21 at 9:15 AM, R1 stated upon interview, "I was given this handout form and it shows the Director of Nurses (V3) and Administrator (V2) and Resident Care Manager and also somebody called (V4-Assistant Director of Nurses). I have not heard word from any of them and they don't return phone calls. I spoke to the Administrator several months ago about the smell in the halls	S9999		

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S9999	Continued From page 2 but recently I've been having problems with the nurses here coming to help me go to the bathroom. They just don't come. There is big problem here with them coming to help me to go to the bathroom or change my brief. When they Certified Nurse's Aid's (CNA) come, they act like they are doing me a favor. I have to use my "toileting tickets" sparingly because I don't want to run out of them otherwise, I will be sitting in my feces until the next shift comes along." Surveyor asked what "toileting tickets" were and who created these tickets, R1 stated, "No I made that up because I literally have to ration the times, I pull this call light for help because they will not come as they tell me I use it too often. I had a nurse actually snap at me and say, "You have to go again?" I was afraid to ask for help after that and made me feel that I used my call light too much so I'm afraid that I will run out of "toileting tickets" but I can't help how my bowels are. It's humiliating to sit in your own feces and urine but that is what I have to do." (R1 was getting visibly emotional and upset). R1 said, " Staff here do the least possible work and I have to suffer throughout this, this is not right. I have told every nurse who takes care of me and it just falls on deaf ears, that is why I tried contacting those other people on this list and then I called you (referring to public health). I shouldn't be treated this way, and neither should anyone else that has to live here." At 9:20 AM, R1 asked surveyor to wait to witness the response when she pulled the call light. The light lit up on the wall beside R1's bed and beeped outside another light outside of R1's door which was clearly visible and audible to anyone in the hall; 30 minutes passed, and no staff came to see what R1 needed. Surveyor left R1's room and approached V8 (RN) who was at the nurses	S9999		

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S9999	Continued From page 3 station. V8 stated, "I take care of this section (pointing to the opposite aisle R1 resided in). That is V9 (LPN) section (referring to the R1's hallway). She's (V9) somewhere around here. She said, "Do you need anything?" Surveyor asked the level of care the floor R1 was on, V8 stated, "This is the skilled care floor. It's a lot of heavy care people, some confused, some not." At 9:55 AM, R1's call light was still beeping and with the light still on with no one observed going in to attend to R1. At 10:10 AM, surveyor observed R1's call light was off and asked R1 how she was doing. R1 stated, "Someone finally came and changed me. But see what I mean. You're even here (referring to public health) and it takes them this long to come. Can you imagine the other shifts when you're not here? This is what I've been going through and no one listens to me. I can't take it anymore. I'm going to talk to my daughter to get me out of here." 2. R2 is an alert and oriented 70 year old with diagnoses listed in part but not limited to: muscle weakness, hemiplegia, aphasia and cerebrovascular disease. R2's most current care plan with goal date of 11/7/21 shows: "Toileting, (R2) requires extensive assistance. R2 will have toileting needs met with the assistance of 2 people." On 8/14/21 at 9:55 AM, R2 was observed in bed flat on her back as V6 (Certified nurse's aide) was standing next to her and arguing with R2. V6 was overheard telling R2, "You'll have to wait, I got a lot of other people to do!" Surveyor entered the room and asked V6 if she said what the surveyor heard, V6 stated, "I was just trying to tell her I got	S9999		

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S9999	Continued From page 4 too much work and I still got to make this bed here (pointing to R2's roommate bed) and I got more that are waiting to be cleaned up." Surveyor asked whether they were short staffed, V6 stated, "Yes, somebody called off, so I got to do more so I tell her that she has to wait. The other shift left a lot of stuff for us to do, they don't do anything (referring to the previous shift before her.) Surveyor asked whether R2 needed to be informed of the facility's staffing issues, V6 stated, "I don't know. I just tell her, so she knows why she has to wait. It's too much!" V6 then abruptly left the room without indicating whether she was going to assist R2 or not. R2 stated, "She's something isn't she (referring to V6)." Surveyor asked if she needed to be cleaned up (referring to her incontinence pad), R2 stated, "Yes, I've been waiting long." Surveyor asked how long she was waiting, R2 put three fingers up to designate the length of time." Surveyor clarified whether she waited three hours, R2 nodded "yes" and stated in a slow soft voice, "It happens all the time especially in the early morning. You see how she talks down to me like I'm a baby. I have to wait for the next shift until I get changed. It makes me very sad and depressed and also angry. I shouldn't be treated this way, no one should." V2 (Administrator) at 11:55 AM was informed of the concerns of abuse/neglect but did not comment on concerns brought forward except stating, "I will look into it." Facility policy dated 1/26/2000 (revised 1/6/2017) titled "Abuse and Neglect" states in part but not limited to: "Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to: freedom from corporal punishment,	S9999		

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S9999	Continued From page 5 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 community staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident. Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents within their hearing distance. Examples of verbal abuse include threats of harm and intimidation. Mental abuse includes humiliation, harassment, threats of punishment or deprivation. Neglect means the failure of the community (facility), its associates, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." (B)	S9999		