STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510526	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF ADDISON	1651 W LAKE ST ADDISON, IL 60101

(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
A 000	Initial Comment Original investigation of FRIs IL 180363 and IL 181889. IL 181889 - No violations cited. IL 180363 - 295.6000 a) 13) and 295.6010 c) and d)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; GENERAL VIOLATION Based on record review and interviews, the establishment failed to prevent verbal abuse and neglect of one of three sampled residents. (R1) Findings include: Facility "Abuse and Neglect" report dated 10/27/24 reads, "A resident's (R1) wife personally reported concerns to the writer (E2 Director of Health Services) regarding inappropriate behavior from staff (E3 Caregiver and E4 Caregiver)	A6000		

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A6000	Continued From page 1	A6000		

towards her husband (R1). The resident's son (Z2) had witnessed the incident and informed his mother (Z1 R1's Wife). The writer and the wife called the son to discuss it further. The son explained that he visited (R1) around 9 p.m. after the nurse had informed his mother that (R1) was very confused. He (Z2) arrived to find his father sitting in the living room with two caregivers (E3 an E4), who repeatedly told (R1) that he was a "Bad Boy" and instructed (R1) to repeat it. The son felt that his father's quick response suggested this behavior might have occurred previously. When the son tried to take (R1) back to his room using a wheelchair, he noticed a missing footrest. Upon asking about it, one caregiver (E3 / E4) told him to pull the chair backward, saying "that's what we do." The son, concerned about his father's stiff legs and unwilling to drag him, retrieved the footrest himself and took (R1) to his apartment. Despite the son being present and assisting (R1) to the bathroom and putting him to bed, neither caregiver came to check on the resident. The son also observed that the caregivers were on their personal phones during his visit, remaining seated and unengaged with (R1). Following further investigation, (E1 Executive Director and E2) spoke with the two caregivers (E3 and E4) involved as well as the nurse (E5) on duty, and concluded that emotional abuse and neglect had occurred. Both employees (E3 and E4) were subsequently terminated from their positions."

On 12/9/24 at 4:35 P.M. Z2 (R1's Son) stated that he had come in on 10/27/24 at around 8:45 P.M. to help R1 because R1 was having hallucinations and staff had called them to let them know. Z2 stated that when he arrived to the facility, R1 was sitting in the dinning room. E3 and E4 were with R1 at this time, and they were saying to R1, "You

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A6000	Continued From page 2	A6000		

are a bad boy" several times. Z2 stated that they made R1 repeat back to them, "I'm a bad boy". Z2 stated that it was very upsetting to hear this but he did not want to lose his cool right then. Z2 stated that he said he was going to take R1 back to his room in his wheelchair. Z2 stated that R1's wheelchair did not have the footrests on it, so he asked the caregivers (E3 and E4) about the footrests, and they told Z2 to just turn R1 around backwards and drag his feet because that's what they do. Z2 stated that he refused to do that and went to R1's room and found the footrests. Z1 took R1 back to his room. Z2 stated that neither E3 or E4 came into R1's room to help R1 to the bathroom or to bed, so Z2 had to do all the care himself. Z2 stated that when he got into his car to leave, he broke down and cried. Z2 called Z1 at that time (around 10:00 P.M.) and told her what all had happened. Z2 stated that Z1 then called and talked to E5 about what Z2 had witnessed.

On 12/9/24 at 10:40 A.M., E2 stated that she was informed by R1's wife (Z1) on the morning of 10/28/24 around 10:00 A.M. about what Z2 had witnessed the night before. E2 stated that Z1 and herself called Z2 on the phone to get Z2 to explain the details to E2. E2 stated that Z2 told how E3 an E4 were telling R1 he was a "Bad Boy" and making R1 repeat this back to them. Z2 stated that when he went to take R1 back to his apartment in his wheelchair, Z2 noticed there was a footrest missing. When he asked E3 and E4 about the footrest, they told Z2 to just pull him backwards because that's what they do. Z2 stated that he refused to pull R1 backwards and drag his feet. So Z2 went to R1's room and retrieved the footrest himself. Z2 stated that after he got R1 back to R1's apartment, the caregivers never came in to help R1 go to the bathroom or help him to bed. Z2 stated he had to do that. E2

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A6000	Continued From page 3 stated that Z2 was to the point of tears when telling what had happened. E2 stated that the two caregivers (E3 and E4) were terminated for emotional abuse and neglect.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. GENERAL VIOLATION Based on record review and interviews, the establishment failed to report an allegation of abuse and neglect immediately to management for one of three sampled residents. (R1) The establishment then failed to remove the perpetrator from direct contact with the residents. Findings include: On 12/9/24 at 4:35 P.M. Z2 (R1's Son) stated that he had come in on 10/27/24 at around 8:45 P.M.	A6010		

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A6010	Continued From page 4	A6010		

to help R1 because R1 was having hallucinations and staff had called them to let them know. Z2 stated that when he got to the facility, R1 was sitting in the dinning room. E3 and E4 were with R1 at this time, and they were saying to R1, "You are a bad boy" several times. Z2 stated that they made R1 repeat back to them, "I'm a bad boy". Z2 stated that it was very upsetting to hear this but he did not want to lose his cool right then. Z2 stated that he said he was going to take R1 back to his room in his wheelchair. Z2 stated that R1's wheelchair did not have the footrests on it, so he asked the caregivers (E3 and E4) about the footrests, and they told Z2 to just turn R1 around backwards and drag his feet because that's what they do. Z2 stated that he refused to do that and went to R1's room and found the footrests. Z1 took R1 back to his room. Z2 stated that neither E3 or E4 came into R1's room to help R1 to the bathroom and to bed, so Z2 had to do all the care himself. Z2 stated that when he got into his car to leave, he broke down and cried. Z2 called Z1 at that time (around 10:00 P.M.) and told her what all had happened. Z2 stated that Z1 then called and talked to E5 about what Z2 had witnessed.

R1's progress note written by E5 (RN) dated 10/27/24 at 11:28 P.M. reads, "Received a call from (R1's wife Z1) wanting to file a complaint about what happened between her son (Z2) and caregivers. (E3 and E4) Son came over to help (R1) go to sleep because he was not able to go to sleep. After son left, (E5) received a call from (Z1). (Z1) notified (E5) that the caregivers were disrespectful. (Z2) said that the caregivers mentioned to (R1) "You are being a bad boy". (Z2) also mentioned that the caregivers did not help (R1) go back to bed. (Z2) was the one who helped (R1) back to bed."

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A6010	Continued From page 5 On 12/9/24 at 10:30 A.M., E1 (Executive Director) stated that Z1 (R1's Wife) had called E5 (RN) on 10/27/24 at around 11:00 P.M. and told E5 that her son (Z2) had witnessed E3 and E4 speaking to R1 inappropriately and neglecting to help R1 with cares. E1 stated that E5 did not inform E1 and or E2 (Director of Health Services) about the allegation that night. E1 stated that it was not until the next day around 10:00 A.M., when Z1 came into the facility and informed E2 what had happened the night before. E1 stated that E3 was working that next day on day shift 10/28/24 and would have been suspended if E5 would have informed E1 of the allegation at the time E5 was told. E1 stated that E5 was counseled about the need to immediately inform E1 of any allegations of abuse or neglect. Facility "Resident Abuse" policy reads, "All allegations or incidents of abuse must be reported immediately to the Director of Health Services, Executive Director, and the Department Manager in person or by phone...."	A6010		