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	IL6014781	A. BUILDING: _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

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S 000	Initial Comments Complaint investigation 2084609/IL123833	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690 a),b), and c) 300.1040 c) and d) 300.1210 a), b) and d) 6) 300.1810 c) 3) 300.3240 c), d), and f) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional	S9999	**Attachment A** **Statement of Licensure Violations**	

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Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1040 Care and Treatment of Sexual Assault Survivors
c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement can determine whether they have evidentiary value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault.
d) The facility shall notify the Department and draft a descriptive summary of the alleged sexual assault pursuant to the requirements of Section 300.690

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the

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resident's guardian or representative, as applicable.

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1810 Resident Record Requirements

c) Record entries shall meet the following requirements:

3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports

Section 300.3240 Abuse and Neglect

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.

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d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.
f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to notify the Department immediately after learning of sexual assault allegation, failed to do a thorough investigation and interview all parties involved, failed to take reasonable steps to preserve evidence of the assault, failed to obtain physician's order for hospital transfer, failed to notify the physician and resident representative immediately after the assault, failed to ensure all cognitively impaired residents are supervised, failed to send both residents for hospital examination following the assault, failed to re-assess R3's cognition status, failed to document all observations made by direct care staff, failed to care plan a sexual behavior exhibited by an oriented male, and failed to follow their abuse policy for 2 (R1, R3) of 3 residents reviewed for sexual assault in the sample of 3 residents.

The finding include:

R1 is a 63 year old, ambulatory female who has

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severe cognition loss per the Brief Interview Mental Score (BIMS) of 01 in the quarterly MDS (Minimum Data Set), dated 4/9/20. R1 has been a resident in the facility since 7/27/18 with diagnoses that include: Coronary Artery Disease, Hypertension, Diabetes Mellitus, Arthritis, Non-Alzheimer's Dementia, Depression, Chronic Obstructive Pulmonary Disease, Dysphagia and Gastrostomy Status. The MDS, dated 5/22/20, documents discharged with return anticipated. Nothing documented that resident went to hospital. There is no physician order to send to hospital. R1 is no longer in the facility, and never returned after the 5/22/20 per MDS, nurses' notes, and interviews.

R3 is an oriented, 65 year old ambulatory male who was admitted to the facility on 10/4/19 per the quarterly MDS, dated 5/19/20. R3's diagnoses include Atrial Fibrillation, Hypertension, Renal Insufficiency, Diabetes Mellitus, Hyponatremia, hyperkalemia, Seizure Disorder, Bipolar, Schizophrenia, glaucoma, Altered Mental Status and mild cognition-communication deficit. The MDS, dated 5/22/20, documents discharged with return anticipated. Nothing documented that resident went to hospital. There is no physician order to send to hospital. R3 is no longer in the facility and never returned after 5/22/20 per MDS, nurses' notes and interviews.

On 6/24/20 at 11 AM, V2 (Director of Nursing) stated that R1 and R3 are no longer in the facility.

On 6/25/20 at 12:12 PM, V2 stated the head to toe assessment was done with no findings. V2 stated that V11 (Registered Nurse) did the assessment, and it should be in the clinical record and risk management.

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On 6/24/20 at 11:24 AM, V1 (Administrator/Abuse Coordinator) stated she received the allegation from V4 (Dementia Coordinator/Psychiatric Rehabilitation Service Counselor/PRSC) who received the allegation from V3 (Certified Nurse Aide/CNA). V1 says that V3 was walking by, it was the shift change around 3:30 PM on 5/21/20, when V3 says she saw R3 (male resident) with his privates in R1's mouth (female). V1 says she had V3 demonstrate the assault, and V3 demonstrated R3 having leg/foot on bed and jiggling his privates in front of R1. R1 was seated on her bed. V1 stated that both residents have dementia and denied it happened.

On 6/24/20 at 4:10 PM, V3 (CNA) stated she was doing her rounds on May 22nd at 2:45 PM, normally works 3 to 11 shift; it was a Wednesday when she saw R3 on R1's bed with his penis in her mouth. V3 stated that R1 was seated upright in the bed, due to Gastrostomy Tube infusing, and was dressed in a hospital gown. V3 stated that R3 was kneeling on the bed with his penis in R1's mouth. When she asked what was going on, R3 stopped, got off bed, put his penis in pants, and zipped his pants. V3 told R3 that he would be reported. V3 went to the nurses' station and telephoned the receptionist and asked for the administrator. Receptionist asked why, and was told of the assault. Receptionist stated that V9 (Social Service Director/Psychiatric Rehabilitation Service Director) would come to the 3rd floor for report. V3 says that she saw V4 (PRSC) and told her of the assault. V3 stated that R3 was removed and placed at the nurses' station and monitored, then moved to 2nd floor. R3 told V4 that R1 is his girlfriend, which is untrue. V3 says that R3 has behavior of masturbating in his room. V3 stated she reported the sexual assault the same day she saw it, and was adamant it was a

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Wednesday. Told her that Wednesday is the 20th, V3 stated she must of written the wrong date in cell phone but it was a WEDNESDAY. V3 stated that on her way out of facility, she went to V1 (administrator) and asked if she was aware of R3's assault, and V1 replied yes. V3 stated the floor is for dementia residents but there are alert, oriented residents on the floor also.

On 6/25/20 at 11:11 AM, V4 (PRSC) stated it happened on 5/20/20, between 2:30 PM to 3 PM, when V3 (Certified Nurse Aide) came to her and stated R3 was standing in front of R1 in her room with his penis out in his hand and in R1's mouth. V4 stated that V3 then stated she was not sure if penis was in her mouth. Asked why her statement was written up 5/24/20, 4 days after the event, V4 stated she was going out of town and left the facility before writing up the statement. V4 stated she only provided a statement, and was not interviewed about the incident. V4 stated it was the administrator who made the decision to send R3 to the 2nd floor, and not out of the facility immediately. V4 stated when R3 was admitted to the facility he was very confused so put on the 3rd floor, a closed unit. But during his stay he presented as oriented times three, and knowing right from wrong. V4 stated she did the BIMS for the 5/19/20 MDS, and admits that she did it quite early in the morning, and R3 was a little groggy waking up. V4 stated he had trouble recalling the 3 words, could only recall 2 words. She was his assigned PRSC and stated not to be aware of R3's behavior of masturbating.

On 6/25/20 at 9:52 AM , V1 (administrator) stated she failed to report allegation of sexual assault immediately to the Department, to the resident representatives, and the attending physician for R1 and R3. V1 stated she knows she should

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have notified the Department on 5/20/20, day of incident, and should have transferred R3 on 5/20/20 to a hospital. V1 stated she was the one to write up the staff interviews along with V10 (Regional Director) and failed to date, and obtain signatures and titles of staff. V1 stated V2 (Director of Nursing) did the assessments on R1 and R3 after the sexual assault. V1 stated she failed to write up R1's and R3's statement, but both denied sexual assault happened. V1 stated she also failed to document V3's demonstration of the assault.

On 6/25/20 at 1:01 PM, V5 (R3's sister) stated that R3 has been in and out of psychiatric facilities his whole life. V5 stated R3 was living in assisted living prior to going to this nursing home. While he was in assisted living, he was not taking care of himself and had poor hygiene and staying in the bed. R3 was sent to the hospital, it was the hospital staff who informed her of R3's masturbation behavior. V5 stated that R3 is not a bad person, but a mentally ill person. Stated that R3 was put on the closed unit because he was so confused and weak. After a couple of months, he started to improve mentally and physically. V5 stated that R3 is oriented and knows right from wrong. V5 stated she was contacted by a female staff member who told V5 that R3 was being sent to the hospital (2 days after the incident) for "inappropriate behavior". V5 stated she needed to press the staff member to say what was inappropriate. Staff member told V5, R3 "was having sex with a female". V5 stated she did not understand why this was an issue if both adults are consenting. V5 stated that R3 told her that R1 was his friend.

On 6/25/20 at 1:45 PM, V6 (CNA) stated she was assigned to R3 on 5/20/20, the 7 to 3 shift. V6

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stated she saw R3 in the dining room sitting and looking out window around 2:30 PM when she was doing her rounds. V6 stated that R3 could hold a conversation with staff. R3 is usually pleasant and walks the unit or stays in his room. She stated she heard from other C.N.A.s about R3's masturbation but never witnessed it herself.

On 6/25/20 at 4:55 PM, V1 stated there is no physician orders for R1 and R3 to be sent out for evaluation after the assault. Nor is there a physician order to discharge R1 and R3 from the facility. V1 stated that V2 (D.O.N.) who was present in room, stated the order was verbal and should have been written in progress note. Informed them there is no progress note on discharge.

On 6/25/20 at 2:33 PM, V7 (MDS/Care Plan Coordinator) stated that V4 (PRSC) would have care planned the behavior of R3's masturbating. V7 stated she knows nothing about this behavior. R3 was not care planned for this behavior.

On 6/25/20 at 5:45 PM, V8 (Psychiatric Nurse Practitioner) stated she conducted a telemedicine call with a nurse and V9 (SSD/PRSD) on 5/20/20 at 3 PM. (minutes after the sexual assault). V8 stated there was no mention of any sexual assault by R3. V8 stated that R3 is grossly oriented : meaning he is oriented by 3 to 4 spheres. V8 stated that R3 knew the difference of right and wrong. R3 knows who he is, where he is, he can recall details from the past and present. V8 stated her biggest problem is the nurses do not document. A resident will voice an issue that the nurses are aware of but they fail to document it. Nurses will say they informed the social service department. It makes no sense for the Social Service to document it when the

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nurses know of it first-hand. It makes it difficult for her to do the job. V8 stated she never heard of any masturbation issue or any issues from the nurses about R3. V8 stated that R3 is now residing in a psych nursing home.

On 6/26/20 at 12:30 PM, V11 (Registered Nurse) stated she did an assessment on R1 and R3 by looking at their skin and taking their vitals. She stated the assessment should be in the clinical record and/or risk management report. V11 stated she did contact the physician about sexual assault but was not given any orders. This was not documented in the clinical records. V11 stated she heard from the aides about R3's masturbation behavior but she never witnessed it herself. V11 stated she worked the 3 to 11 shift on 5/20/20, and saw no police in the facility.

The incident reports were incomplete and inaccurate with notifying (date and time) the resident representative and attending physician, R3's cognition not documented, and no conclusion of the incident report. Both residents remained in the facility after the sexual assault for 2 days. There is no date on incident report as to when it was completed. The incident report was not faxed to regional office.

Review of the facility's abuse investigation was lacking interviews with R1, R3; incomplete interviews that lacked dates, titles and signatures. No follow up or conclusion for the assault. The initial investigation was sent to the regional office 2 days after the assault. The final report which lacked a conclusion was sent to the regional office on 5/27/20, seven days after the sexual assault. A police report was provided with no date on it as to when the report was filled out. Report only has time of assault.

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S9999	Continued From page 10 The facility's policy labeled ABUSE PREVENTION PROGRAM documents : If you suspect ABUSE, separate alleged perpetrator and assure all residents' safety. Notify the administrator and the director of nursing immediately. Complete incident report immediately. Do not leave building until above is completed. Fax report to the Illinois Department of Public Health immediately. Under the investigation portion of the policy : All incidents, allegation or suspicion of abuse against a resident will be documented and result in an investigation. The charge nurse must complete an incident report and obtain a written, signed and dated statement from person reporting the incident. A completed copy of the incident report and written statements from witnesses will be provided to Administrator within 24 hours of the occurrence. The final report will be completed in 5 working days with a conclusion of the investigation based on facts. Any investigation that concludes abuse against a resident will be reviewed by the Quality Assurance Performance Improvement Committee for possible changes in facility practices to ensure that similar events do not occur again. As part of the social history and the MDS assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behavior that might lead to conflict. Any incident that involves a crime toward a resident will be reported with in 2 hours of the incident to the State, to the resident representative, to the attending physician and any law enforcement when it is sexual abuse of a resident by another resident. (A)	S9999		