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S 000	Initial Comments Annual Licensure and Certification Survey An extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.695b)3) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240f) 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. Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 3) Sexual abuse of a resident by a staff member, another resident, or a visitor 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. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) 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. (Section 3-610 of the Act) 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. (Section 3-610 of the Act)	S9999		

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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 observation, interview and record review, the facility failed to prevent R37's repetitious sexual, physical, verbal, and mental abuse towards four residents reviewed for abuse (R2, R7, R41 and R44) on the sample list of 42. R37's repetitious abuse resulted in psychosocial harm to R2, R7, R41, and R44. Facility failed to implement their abuse prevention policy by failing to complete an investigation of an allegation of sexual and verbal abuse and immediately report multiple witnessed allegations of physical, sexual, verbal and mental abuse incidents to the facility Abuse Prevention Coordinator, local law enforcement and the State Survey Agency. The Facility failed to protect all residents residing in the facility by failing to remove the alleged perpetrator from potential contact with other residents in the facility. These failures have the potential to affect all 43 residents residing in the facility.

Findings include:

The facility's Abuse Prevention Program dated 11/28/16 documents the facility affirms the right of the residents to be free from abuse. "This facility prohibits mistreatment and abuse of its residents

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and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This will be done by orienting and training employees on how to recognize and report occurrences of mistreatment, exploitation, neglect or abuse immediately to supervisory personnel, training on activities that constitute abuse, establishing an environment that promotes resident security and prevention of mistreatment and abuse of residents. This will also be done by identifying occurrences and patterns of potential mistreatment and abuse of residents, resident abuse prevention, immediately protecting residents involved in identified reports of possible abuse, implementing systems to investigate all reports and allegations of mistreatment and abuse of residents promptly and aggressively, making the necessary changes to prevent future occurrences and following procedures for reporting of potential incidents of abuse. This facility is committed to protecting the residents from abuse by anyone including other residents. Instances of abuse of all residents irrespective of any mental or physical condition, cause harm, pain or mental anguish. Sexual abuse is non-consensual sexual contact of any type with a resident; verbal abuse is the use of oral, written or gestured language that includes disparaging and derogatory terms to residents or families regardless of their age, ability to comprehend or disability; mistreatment means inappropriate treatment of a resident. During orientation of new employees, the facility will cover at least the following topics: Sensitivity to resident rights and needs; Staff obligations to prevent and immediately report abuse, neglect to supervisory

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personnel and administrator, and resident abuse preventions. Resident and family concerns will be recorded, reviewed, addressed and responded to using the facility's concern identification procedures. Employees are required to immediately report any occurrences of potential/alleged mistreatment and abuse of residents they observe, hear about or suspect to a supervisor and the administrator. Supervisors shall immediately inform the administrator or the designated representative of all reports of potential/alleged mistreatment and abuse of residents. Upon learning of the report, the administrator or designee shall initiate an investigation. The facility will take steps to prevent mistreatment and abuse of residents while the investigation is underway. Residents who allegedly mistreat or abuse another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine most suitable therapy, care approaches and placement considering his or her safety as well as the safety of other residents in the facility. Once an allegation of abuse is received, the administrator will designate a person to take charge of the investigation. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. The administrator will submit the report of the result of the investigation and any corrective actions taken to the state survey agency within five working days of the reported incident. The facility must ensure that all alleged violations involving mistreatment or abuse are reported immediately to the administrator of the facility and to other officials in accordance with State law. If the events that cause the reasonable suspicion result in suspected criminal sexual

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abuse, the report shall be made to at least one law enforcement agency and the State Survey Agency immediately after forming the suspicion (but not later than two hours after forming the suspicion). The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment or abuse of residents and that an investigation is being conducted. If there is "any reasonable suspicion of a crime" as defined by local law, the administrator shall immediately (not later than two hours after forming the suspicion in the event of suspected criminal sexual abuse) notify local law enforcement. These situations include sexual abuse of a resident by a staff member, another resident or a visitor. Resident Protection Investigation Paths- Possible Sexual Abuse, determine if the allegation involves either physical sexual contact involving penetration, verbal harassment or physical contact that did not involve penetration. If the allegation is verbal sexual harassment or physical contact that did not involve penetration, proceed with investigation procedures. Even if the resident might not comprehend the disparaging content, verbal or mental abuse might have taken place if the intent was willful and the content abusive, demeaning or humiliating. Verbal or mental abuse is just as much more harmful if the intent was willful (deliberate), the content abusive and the resident intimidated, frightened or harmed by the remarks. Possible Neglect based on the allegation determine what services were not provided to the resident that resulted in side effects such as mental anguish and emotional distress."

R37's Social Service Admission Assessment dated 10/11/18 documents R37's reason for admission to the facility as previous "facility

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unable to handle behaviors" and that this "problem has existed" for "a while/years." This assessment documents R37 exhibits "Dementia with Behaviors - Sexual Comments." R37's Social Services Notes dated 10/11/18 documents R37 "only" talks about "sex" or the war. Social Service Notes dated 10/18/18 document R37 frequently changes the subject to sexual comments when talking and that R37 is not easily redirected.

R37's Behavioral Wellness Physician Note dated 4/30/19 at 2:30pm documents R37 has been discharged from two "other nursing homes due to sexually inappropriate behavior." This note documents R37 has recurrent episodes of sexually inappropriate behavior at the facility.

R37's pharmacy Consultation Report dated 6/18/19 documents R37 has hypersexuality target symptoms.

R37's Physician's Note dated 7/13/19 documents R37 has increased behaviors of "sexual advances and inappropriate touching."
R37's Behavioral Wellness Physician Note dated 8/22/19 documents R37 "continues to be sexually inappropriate when {R37} interacts with female residents." This note documents R37 "has been touching and saying offensive things to other residents." This note also documents facility staff report R37 wheels R37 next to female residents and then R37 "starts touching them and making inappropriate statements."

R37's Behavior Monitoring Records document R37's multiple witnessed sexual, physical, and verbal abuse incidents as follows:

4/9/19 at 2:00pm- R37 propelled self up to other unidentified "resident" and spoke inappropriately

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to them. There is no identified resident for this witnessed incident.

4/19/19 at 9:00am- Asking unidentified "others" if they wanted to have sex before the "warden's" caught them and trying to "rub others" legs. There is no identification of "others."

4/25/19 at 1:00pm- R37 was witnessed "calling others baby" and "asking for inappropriate favors." There is no identification of "others."

5/3/19 9:30am- R37 was witnessed making inappropriate comments to unidentified "residents."

1.) R44's undated Cumulative Diagnosis Log documents R44's diagnoses including Depression, Anxiety and Physical Deconditioning.

R44's Minimum Data Set (MDS) dated 8/7/19 documents R44 is able to make self understood and understands others. This MDS documents R44 is cognitively intact.

R44's Speech Therapy Daily Treatment Note dated 8/22/19 documents R44 "reported being inappropriately touched by another person at the facility." This note documents V31, Speech Therapist "immediately spoke with the (unidentified) program director who spoke with {V1} Administrator and {R44}."

On 10/30/19 at 9:40am, V4, BOM (Business Office Manager) stated V4 recalled "when {R37} touched {R44} (8-22-19)." V4 stated V15, Certified Occupational Therapist (COTA) brought the abuse allegation to "our" attention. V4 stated R44 was "really upset" about the incident that occurred with R37 "touching" R44. V4 stated V4

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heard/witnessed V15 report the allegation to V1, Administrator. V4 stated V1 went and spoke with R44. That is when R44 reported to V1 that R37 had touched R44's genital area. V4 stated V4 identified it as "sexual abuse" and that V4 believes R37 knows what R37 is doing because R37 will watch and look around and over R37's shoulder to see if anyone is watching. V4 stated R37 is able to propel R37's self in the wheelchair and has the ability to approach any female resident who resides in the facility.

There is no documentation in R44's medical record documenting the sexual abuse occurring or that V17, R44's Physician or V28, R44's family were notified. There is no documentation in R37's medical record documenting the sexual physical abuse toward R44.

On 10/30/19, V1, Administrator confirmed the identity of R44 with the sexual abuse incident with R37.

On 10/30/19 at 10:05am, R44 stated when R44 first admitted to the facility "a male resident" touched R44 sexually and also said "dirty" sexual comments to R44. R44 stated R44 knew it was not right and reported it to a therapist. R44 stated R37 "thought" R37 was being sexual as R37 "rubbed breasts, continuing down chest and abdomen and back and forth" over {R44's} vaginal/perineal area. R44 stated the unwelcome sexual physical, sexual verbal abuse was very upsetting to R44. R44 stated R44 feels "terrible and disgusting" and what happened is something R44 will never forget. R44 stated, "it is easy for anyone to remember if it happened to them" when talking about R37 rubbing R44's breasts and taking R37's hand and rubbing over R44's vaginal area. R44 displayed a sad, somber,

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frowning affect during this interview.

On 10/30/19 at 10:24am, V1, Administrator confirmed the identity of identified residents as above with the dates of witnessed sexual physical and sexual verbal abuse.

On 10/30/19 at 10:24am, V1, Administrator stated R44 had reported R44 was "inappropriately touched" by R37 and "pointed (identified) {R37} out." V1 stated when V1 initially asked R44 what happened, R44 "couldn't recall anything." V1 stated R44 is cognitively intact. V1 was unsure if V1 had contacted R44's family when the sexual physical abuse allegation against R37 was made. V1 was unsure of time V1 talked with R44 or who was in the area when V1 was asking R44 about the sexual physical abuse. V1 stated V1 "talked to {R44} and {V28} family and that is where it ended." V1 stated V1 did not complete an investigation and should have as R44 identified R37 as the perpetrator. V1 stated if she would have investigated, V1 would have "seen" R37's documentation of multiple witnessed sexual physical and sexual verbal abuse incidents. V1 stated the sexual physical and sexual verbal abuse by R37 to R44 should have also been reported to local law enforcement and public health immediately and was not. There is no documentation of V1 talking with R44 when the sexual abuse allegations were reported to V1 on 8/22/19. V1 stated the sexual physical and sexual verbal abuse by R37 to R44 should have also been reported to public health immediately and was not.

On 11/4/19 at 11:45am, V28, R44's family stated R44 was "very disturbed" by the incident. V28 stated R44 is "really afraid of {R37} and has a fear" of R37 touching R44 and saying sexual

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verbal comments again. V28 stated R44 is in same hall as R37 and walks to and from meals. V28 stated R44 voiced fear of R37 as R37 goes by/past R44's room every day. V28 stated the incident is a hard thing for R44 and that type of incident especially has upset R44.

2.) R41's Cumulative Diagnosis Log dated 10/1/15 documents R1's diagnoses including Dementia with Behavioral Disturbances and Major Depressive Disorder. R41's 9-25-19 Care Plan documents that R41 has Impaired Cognition and Communication Deficits.

The facility's behavior documentation related to R37's sexual abuse documents incidents of witnessed sexual verbal abuse toward R41 as follows:

1/4/19- R37 approached R41 in the dining room. R41 stated to R37, "I really like juice, don't you?" R37 replied "{R37} would like your juices running all over my face." Staff intervened and told R37 "that talk was inappropriate" and R37 needed to stop now. There is no documentation R37 was removed from contact with R41.

3/17/19- R37 told R41 that R41 "had nice (breasts)" and R37 asked R41 to wrap R41's legs around R37. R41 rolled R41's eyes and stated, "that is sick." V14, Certified Nursing Assistant (CNA) assisted R37 to R37's table in the dining room and told R37 "that was inappropriate." There is no documentation as to where R37 was removed in order to protect R41 from further sexual verbal abuse from R37.

4/3/19- R37 was "re-directed" to "leave {R2} alone" and as R37 "was leaving, (R37) found (R41) and asked (R41) if (R37) could "suck her

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(breasts)." R41 stated, "... you {R37} are too old to be talking like that."

On 10/30/19 at 9:00am, V14, Certified Nursing Assistant (CNA)/Family of R41 stated V14 witnessed some of R37's sexual verbal abuse to R41. V14 stated V14 reported the incidents V14 witnessed to the nurse on duty at the time of the incidents and was directed to document the incident in R37's behavior record. V14 stated 3/17/19 R37 was on the way to the dining room when R37 stopped and made sexual verbal comments to R41. V14 stated R41 stated, "you {R37} are gross." V14 stated R41 was upset and disgusted by R37's sexual verbal comments.

On 10/30/19 at 10:24am, V1, Administrator confirmed the identity of R41 with dates of abuse.

3.) R2's Cumulative Diagnosis Log dated 10/1/15 documents R2's diagnoses including Alzheimer's Dementia, Late Onset. R2's 10-9-19 Care Plan documents that R2 has Impaired Cognition and Communication Deficits.

The facility resident behavior documentation related to R37's sexual abuse documents incidents of sexual verbal abuse and sexual physical abuse toward R2 as follows:

3/30/19- V14, CNA heard R37 ask R2 to wrap R2's legs around R37 in the dining room. V14 assisted R37 to R37's table in the dining room. There is no documentation as to location where R37 was removed to in order to protect R2 from further sexual verbal abuse from R37.

3/31/19- at 11:28am V14 documented V14 CNA entered the dining room and "saw {R37} rubbing (R2's) upper thigh." V14 asked R37 what R37

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was doing and wheeled R37 to the dining room table. There is no response documented from R37. There is no documentation as to where R37 was removed to in order to protect R2 from further sexual physical abuse from R37.

4/3/19 (time blank)- R37 was found by V16, Registered Nurse (RN) in the dining room with "hand fondling {R2} genitals." R37 was "re-directed" to "leave {R2} alone" and as R37 "was leaving, (R37) approached (R41) and asked (R41) if (R37) could "suck {R41's} (breasts)."

4/21/19- R37 was observed by V16, RN in the hallway "patting {R2's} buttocks." R37 stated at this time to R2 "I'd {R37} like to get on that, will you make love to me and suck my (penis)?" R37 then proceeded to approach R7 in the hall and asked, "Can I suck your (vagina) dry?" There is no documentation R2 and R7 were protected from further sexual verbal abuse from R37. There is no documentation V1 was notified of the witnessed sexual abuse by R37 towards R2 and R7.
V16 "re-directed" R37 to R37's room by turning R37 around.

9/11/19- at 3:45pm-R37 was observed by V4, Business Office Manager (BOM) "touching {R2's} arm and making sexual comments" V4 "moved" R37 and educated R37 "on how to treat a resident."

9/29/19- R37 "grabbed the arm of {R2}" as R2 was passing R37 in the hallway. R2 tried to pull away from R37 but R37 would not let go. Unidentified staff said, "{R37, let go of her." There is an additional sheet documenting R37 grabbed the same resident {R2} "by arm again." and the unidentified nurse had to tell R37 to "let go."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CENTER	600 MAPLE STREET PIPER CITY, IL 60959

(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
S9999	Continued From page 13	S9999		

There is no documentation R37 was removed from the situation/incident.

9/29/19- after R37 was redirected from sexual and verbal abuse against R2 and when R37 was "further down the hall {R37} asked {R7} can I {R37} suck your (vagina) dry?"

On 10/30/19 at 9:00am, V14, CNA stated on 3/30/19 V14 was walking past and stopped immediately when V14 heard R37 make sexual verbal comment to R2. V14 stated V14 went to the nurse's station to report the incident to the nurse.

On 10/30/19 at 9:00am, V14, CNA stated on 3/31/19 at 11:28am V14 walked past R2 and R37 and glanced and saw R37's hand on R2's thigh. V14 stated R37 was on R2's right side and using R37's left hand to "rub" up close to R2's vaginal area. V14 stated V14 told R37 to keep R37's hands to R37's self. V14 stated V14 went and told the nurses that R37 was touching R2 inappropriately.

On 10/30/19 at 10:24am, V1, Administrator confirmed the identity of identified residents as above with the dates of witnessed sexual, physical, and verbal abuse. V1 stated V1 was not notified of the witnessed sexual, physical, and verbal abuse and should have been notified immediately.

On 10/31/19 at 12:45pm, V32, R2's Family stated V32 was unaware of the witnessed sexual physical and sexual verbal abuse incidents that occurred with R2. V32 stated R2 would be "appalled and angry and would have hit {(him) R37}." V32 stated R2 would never allow another man to sexually touch or make sexual verbal

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S9999	Continued From page 14	S9999		

comments to R2. V32 stated R2 is very dedicated to R2's husband and R2 would be devastated.

There is no documentation that V1, Administrator/Abuse Coordinator was notified of any of the witnessed sexual, physical, verbal or mental abuse documented above.

4.) R7's Cumulative Diagnosis Log dated 8/13/18 documents R7's diagnoses including Alzheimer's Dementia Late Onset, Dementia with Behaviors, Anxiety and Weakness. R7's 8-14-19 Care Plan documents that R7 has impaired cognition and Communication Deficits.

The facility's behavior documentation related to R37's sexual abuse documents incidents of sexual verbal abuse toward R7 as follows:

On 10/31/19 at 1:18pm, V33, R7's Family stated R7 would be devastated to have this sexual verbal abuse happen to R7. V33 stated R7 has "always been a proper lady" and that type of language was not something R7 had been around or had said to R7. V33 stated R7 would be sad if R7 knew what was being said to R7.

On 11/4/19 at 3:45pm, V1, Administrator stated that all instances of R37's repeated witnessed sexual, physical, verbal and mental abuse were abuse incidents towards R2, R7, R41 and R44. V1 stated R37 would look over R37's shoulders to make sure there was not anyone watching and knew what R37 was doing.

The facility's Resident Census and Conditions of Residents dated 10/28/19 documents 43 residents reside in the facility.

(A)

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