STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006407	A. BUILDING: _____ B. WING _____	05/12/2017

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MORTON TERRACE H & R CENTRE	191 EAST QUEENWOOD ROAD MORTON, IL 61550

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS

300.610a)
300.625n)
300.625p)
300.625q)
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 300.625 Identified Offenders

n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this

Attachment A
Statement of Licensure Violations

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evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.

p) The facility shall notify the appropriate local law enforcement agency, the Illinois Prisoner Review Board, or the Department of Corrections of the incident and whether it involved substance abuse, aggressive behavior, or inappropriate sexual behavior that would necessitate relocation of that resident.

q) The facility shall develop procedures for implementing changes in resident care and facility policies when the resident no longer meets the definition of identified offender.

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)

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THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview, and record review, the facility neglected to follow its Abuse Prevention Program and the Illinois State Police (ISP) Criminal History Analysis Report (CHAR) recommendations for one of six residents (R1) reviewed for abuse in the sample of 20. These failures resulted in allegations of inappropriate sexually suggestive comments and inappropriate sexual touching of a female resident (R31) by R1 on three separate occasions. These failures have the potential to affect all residents (R2, R4, R6, R14, R15, R16, R21, R22, R39-R59) residing on the memory care unit.

Findings include:

The facility's Abuse Prevention Program (2/2017) documents the following:

Sexual abuse includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.

VI. Protection of Residents-Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of residents including, but not limited to, the separation of residents.

VII. Internal Investigation- 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or

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suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.

The facility's Abuse Prevention Program (2012) in effect through (1/31/17) documents the following:

VI. Protection of Residents - Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation.

VII. Internal Investigation- 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.

The facility's Abuse Prevention Program (2012) in effect through (1/31/17) documents the following:

VI. Protection of Residents - Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation.

On 5/3/17 E1 provided R1's ISP CHAR dated 5/26/15 which documents R1 is an identified offender and includes the following Security Recommendation Report: (R1) is determined to be "Moderate Risk" for re-offending, and "The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavior changes that may signal a need for closer

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observation or sustained visual monitoring on a time-limited basis."

R1's Minimum Data Set (MDS) dated 11/19/16 documents R1 is cognitively intact, can propel self around the facility in a wheelchair, and has no limitations of upper extremities. R1's Physician Order Sheets dated 7/1/16 through 11/30/16 documents diagnoses of Dementia, Bipolar, Dementing Illness with Associated Behaviors.

R1's current care plan documents (R1) has a history of criminal behavior and fits the "Identified Offender" criteria. Interventions include: appropriate supervision and observation, regular monitoring, attention to behavior changes, visual monitoring if warranted and periodic, on-going reassessment.

On 5/2/17 at 11:15am and 5/3/17 at 12:30pm, R1 propelled self around in the Dementia care unit dining room/activity room. On 5/2/17 at 11:30am and 5/3/17 at 7:45am respectively, R1 fed self lunch and breakfast.

Facility incident report dated 7/1/16 documents a statement by E13 C.N.A. (Certified Nurse Aide) stating that R1 pulled on the front of R31's shirt and stated he wanted to see R31's "boobs". This same incident report documents that a visitor (Z1) also made a statement witnessing the same thing by towards R31 by R1.

Facility state report dated 8/3/16 documents that R1 lifted R31's tee shirt and that other residents were near. On 5/4/17 at 11:30AM E1 verified that she was unable to provide an incident report on this occurrence.

Facility incident report dated 11/3/16 documents

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that R1 lifted the shirt of R31 and inappropriately touched R31. This same report included a statement by E13 C.N.A. who heard R1 say to R31 "let me look at your breast."

On 5/5/17 at 8:30am, E1/current Administrator stated "I didn't know (R1's) history. I did not know (R1) had two other allegations of inappropriate comments.

On 5/4/17 at 10:05am, E27, previous Administrator who investigated the allegation dated 8/3/16, stated (E27) was unable to provide an investigation and could not remember what the investigation had included.

On 5/4/17 at 10:05am, E13, CNA, stated (E13) did not remember exact dates, but (R1) had lifted up R31's shirt and touched R31 inappropriately in the past, and that staff tried to keep R1 away from other residents. E13 stated R1 was not separated from all residents in the memory care unit and no one-to-one supervision was provided. E13 stated R1 is able to propel self around the memory care unit and has full use of (R1's) hands. E13 stated (E13) reported the inappropriate sexual comments and touching to the Administrator each time E13 heard or saw the behavior.

On 5/5/17 at 11:05am, E33 (Housekeeper who works on the memory care unit) stated on several occasions (E33) has seen R1 put (R1's) hand up multiple female residents' shirts. E33 stated (E33) reported the incidents immediately to the nurse on duty, but could not recall dates of the incidents or nurses' names to whom (E33) reported.

On 5/3/17 E1 provided all allegations of abuse since the last survey on 4/19/16. No other

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allegations regarding inappropriate sexual comments or touching by R1 were included.

On 5/4/17 at 10:30am, E4, Social Service Director, reviewed R1's room assignments and stated R1 resided on the memory care unit from 5/5/16 through 8/7/16, 8/13/16 to 1/31/17, and 2/4/17 to present. E4 stated (E4) was made aware of the incidents of 7/1/16, 8/3/16, and 11/3/16 the day following the incidents at the staff morning meeting. E4 stated (E4) then counseled R1 about the incidents, and R1 stated (R1) thought lifting up (R31's) shirt and touching R31 inappropriately "was funny," and "a joke." E4 stated R1 was not cognitively impaired and could propel self around the memory care unit. E4 stated R31 also resided on the memory care unit until discharge on 12/20/16.

On 5/5/17 at 9:15am, E4 stated (E4) was not certain why R1 was placed in the memory care unit but (R1) had resided in the unit for a long time. E4 stated the facility does not have specific criteria to use when determining if a resident would be appropriate for the memory care unit, but R1 exhibits behaviors such as impulse control, impaired judgment, and impaired reasoning which make (R1's) placement appropriate even though he was cognitively intact. E4 stated R31 wandered throughout the unit and it was hard to keep R1 and R31 apart.

On 5/9/17 at 10:27am, E4 stated the facility's unwritten criteria used to determine a resident's appropriateness for the memory care unit. E4 stated a resident's diagnoses, functioning level, ability to participate/benefit from activities, past and current behavior, elopement risk, how easily overstimulated/agitated a resident can be, and cognitive level (no specific level) are considered.

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S9999	Continued From page 7 R31's POS dated 12/2016 documented diagnoses of Alzheimer's disease and Dementia. R31's MDS dated 10/15/16 documented R31 is severely cognitively impaired and wanders daily. R31's care plan effective until R31's discharge 12/20/16 documented "resident's assessments reveal factors that may increase (R31's) susceptibility to abuse," and "(R31) is on our memory care unit, wanders all day long." On 5/5/17 at 9:30am, R1 stated (R1) did not remember (R31) and would not answer any questions. On 5/9/17 at 9:25am, E34, Primary Care Physician and facility's Medical Director, stated "It was not appropriate for R1 to be placed on the memory care unit since (R1) was cognitively intact, (R1's) sexual behaviors are pretty tough to handle. E34 stated "I am unaware of the circumstances surrounding (R1's) admission to the memory care unit. On 5/2/17 E1, Administrator, provided a Resident Room Roster documenting R1, R2, R4, R6, R14, R15, R16, R21, R22, and R39-R59 reside on the memory care unit. (B)	S9999		