

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2022
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NAME OF PROVIDER OR SUPPLIER AMBERWOOD CARE CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103
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S 000	Initial Comments Facility Report Incident Investigation to 9/11/22/ IL152065	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210d)3) 300.3240a) 300.3240e) 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 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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S9999	<p>Continued From page 1</p> <p>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 resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>e) 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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>the facility. (Section 3-612 of the Act) These Regulations are not met as evidence by:</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was free from abuse for 1 of 3 residents (R2) reviewed for abuse in the sample of 7. This failure resulted in R2 showing visible distress when recalling the incident.</p> <p>The findings include:</p> <p>On 10/12/22 at 9:50 AM, V4 Certified Nursing Assistant stated "I was on shift when R3 came up to me and said there is a black guy in there (motioning toward the dining room) touching a white lady where he shouldn't." V4 said she went to the dining room and R1 was sitting next to R2 side by side. V4 said she did not see any touching at that time, but pulled R2 to the side and asked her if R1 touched her. V4 said R2 said he brushed my chest with his hand. V4 said she reported this to the nurse. V4 said she interviewed R1 but he just stared at her. V4 said R1 has touched female staff in the past.</p> <p>On 10/12/22 at 9:55 AM, R3 said he was in the dining room and saw a black guy fondling a white woman R3 said the black guy was sitting right next to her, and she looked like she was out of it. R3 said he left the dining room and told a staff member.</p> <p>On 10/12/22 at 11:07 AM, R2 was in her room watching TV. R2 was talking to this surveyor and answering questions appropriately. R2 was friendly and alert with her head up and looking directly at this surveyor when talking about the activity page in front of her. R2 was in a good mood, easily conversing, and said she was happy</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>with the staff and they helped her when she needed. When asked if anyone had touched her inappropriately before, R2 immediately lowered her head, avoiding eye contact, and quietly said "yes, he touched me in my breast." R2 appeared visibly upset, closed her eyes, kept her head bent down, and would not respond to any more questions. R2 visibly shut down mid conversation. R2 nodded her head when asked if awake, but would not respond further.</p> <p>The facility's Resident Interview with R3 dated 9/12/22 shows "He states he saw the male resident reach over and touch the female resident where he shouldn't have."</p> <p>The facility's Statement from V4 dated 9/11/22 shows "resident came up to me and told me that he saw the black man in the dining room touch R2 where his is not supposed to. I immediately went to the dining room to separate the residents and they were both sitting at the table, but I did not personally see R1 touch R2. I took R2 into a private place to ask her what happened. She told me that she was sitting at the table with R1 and he reached over and swiped his hand across her boob."</p> <p>On 10/12/22 at 10:50 AM, V5 Registered Nurse said R3 is alert and oriented times three and has no behaviors or history of making false accusations. V5 said R2 is alert, answers questions appropriately and able to make her needs know. V5 said R1 is alert to self only, non verbal, and is able to propel self through the hallway. V5 said R1 likes to reach out and grab toward the bottom of your shirt. V5 stated "you watch out for him and quickly move when he reaches out."</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>On 10/12/22 at 11:00 AM, V6 Licensed Practical Nurse said R1 has behaviors of being sexually inappropriate toward staff. V6 said he tries to reach out and grab your bottom. V6 stated "I know to watch out for R1."</p> <p>On 10/12/22 at 9:32 AM, V3 Certified Nursing Assistant said she heard that R1 touched R2 in the dining room. V3 said R1 has touched staff before and is mobile and able to reach out.</p> <p>R1's Care Plan dated shows "The resident displays inappropriate sexual behaviors towards others...7/8/22 inappropriately grabbing at staff during showers.....9/11/22 resident reached out and touched another residents chest.....9/16/22 resident continues to attempt to inappropriately touch female staff during cares."</p> <p>R1's Progress Notes dated 9/18/22 shows "writer standing at med cart, R1 propelling self past writer, than reached out in attempt to touch writer inappropriately."</p> <p>On 10/12/22 at 12:00 PM, V1 Administrator said didn't substantiate the abuse because the resident didn't remember doing it. V1 said based on one statement she obtained the touching happened. V1 said the intervention put in place after this event was to make sure residents were not left alone in common areas with R1. V1 said to her knowledge she was not aware of any behaviors since this incident.</p> <p>The facility's Abuse Policy dated 11/28/17 shows "this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment."</p> <p>(B)</p>	S9999		

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