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S 000	Initial Comments FRI of 1/8/2024/IL168621	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 300.3210t) 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 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	S9999		

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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 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These Requirements were NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from sexual abuse. R6 was found with R7 in his closed bedroom with a chair placed to block the door. R6 is severely cognitively impaired and she was sitting on R7's bed, exposed, with her pants and incontinence brief around her ankles. R7 was naked from the waist down. Staff also failed to identify R7's behaviors (getting into a female resident's bed and disrobing in the hallway) as potentially sexually inappropriate behaviors, and failed to report those behaviors.

This applies to 2 of 4 residents (R6, R10)

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reviewed for abuse.

As a result, this type of inappropriate, nonconsensual sexual contact would reasonably cause psycho-social harm, and it can be determined that a reasonable person in R6's position would have experienced psycho-social harm (such as humiliation and fear) as a result of the sexual abuse.

The findings include:

The facility's initial January 8, 2024 IDPH (Illinois Department of Public Health) Reportable Event from R6's Electronic Medical Record (EMR) showed "On 1/8/2024 [no time] staff reported seeing [R6] to be sitting by the side of her bed with her undergarments down to her ankles and [R7, a male resident] was by the side of the bed and pulling his pants up ...."

On January 10, 2024 at 03:02 PM, V8 (Activity Aide) said that around lunch time on January 8, 2024, she left R6 and R7's unit (locked dementia unit) to do the lunch trays in the dining room outside the unit. V8 said before she left, R6 and R7 were sitting together by a window. V8 said when she returned, R6 and R7 were no longer in the dining room and she started gathering residents for lunch. V8 said when she arrived at R7's room, his door was closed, and no one answered when she knocked. V8 said when she opened the door, a chair fell that was being used to block the closed door. V8 said she saw R6 sitting in the middle R7's bed with her pants and incontinence brief around her feet. V8 stated R7 was standing about a foot away from R6, wearing no pants or incontinence brief. V8 stated "I saw them both with no bottoms on" and told R6 she had a phone call and needed to go eat lunch, and

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ran to get the nurse (V6, RN/Registered Nurse). V8 stated she did not take R6 with her. V8 said she went to get the nurse and R7 covered his perineal area with clothing. V8 said R7 was confused and had a behavior of going to other residents' rooms.

V8 continued, R7 is one of our newest residents from the beginning of December. V8 said he walked independently. V8 stated R7 gets confused so sometimes he goes to another room, sees it's not his and then goes back to his room. V8 stated R6 has been at the facility for a while, and she doesn't have that behavior. V8 stated R6 follows directions, and she has never seen her having this behavior. V8 stated for R7's first few weeks, R7 was getting adjusted, so he was alone and would sit by the TV or in the dining room or would walk in the hallways.

On January 10, 2024 at 2:00 PM, V6 (RN/Registered Nurse) said on January 8, 2024 when V8 went to deliver R7's tray, R7 had put a chair on the back of the door and when she tried to open the door, the chair fell. V6 stated when she got to R7's room, R7 told her that R6 "needed help with something" and that was why he had brought her into his room. V6 stated she completed a full body assessment, including checking for semen between R6's legs, and everything was ok. V6 stated when she asked R6 about the incident, R6 was sitting on the bed and smiling, and R6 told her R7 had brought her to his room. V6 stated R6 likes to sit with people, rub their hands and she wanders. V6 stated R6 does not know what room she is going into, but R6 and R7 can both walk. V6 stated R7's pants were completely off, but he covered himself with clothes, leaving his buttocks exposed. V6 stated R6's pants and brief were down, and she thought

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staff caught them "in the process" before anything happened. V6 stated R6 and R7's families were told that based on their assessment, it was probably going to happen that they were going to have sex. On January 11, 2024 at 10:22 AM, V6 stated R6 is a very pleasant lady. V6 added R6 has not had issues with the male residents.

R6's medical record showed she was admitted with diagnoses including dementia, Alzheimer's, restlessness and agitation, delirium, and altered mental status. R6's October 16, 2023 Minimum Data Set (MDS) showed she is severely cognitively impaired.

On January 10, 2024 at 2:50 PM, R6 was sitting in the dining room flipping through a magazine. R6 said she was doing good and said she ate her lunch when she was asked about it. R6 laughed inappropriately during the conversation with Surveyor. R6 was unable to answer questions regarding incident on January 8, 2024.

On January 10, 2024 at 2:19 PM, V12 (CNA) stated R7 needs to be watched for wandering. V12 stated sometimes she has seen R7 go into other residents' rooms, but she redirects him. V12 stated when R6 moves, it is because she needs to use the bathroom.

On January 11, 2024 at 11:28 AM, V9 (CNA) stated she worked on January 8, 2024. V9 stated R6 is nice, and "she doesn't know what she is doing." V9 stated R6 is able to walk by herself and she does not go into other residents' rooms. V9 stated R7 walks by himself, and he is always walking. V9 stated R6 and R7 did not have a relationship and she did not get any special instructions about R7 and did not know what happened on January 8, 2024.

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R6's Care Plan listing does not include any care plan that shows she is at risk for abuse. R6's impaired cognitive function/dementia or impaired thought processes related to Alzheimer's care plan (revised January 30, 2022) showed a goal to be able to communicate basic needs. Interventions include to ask her yes/no questions and cue, reorient, and supervise as needed. R6's other impaired cognitive function or impaired thought processes care plan (revised February 4, 2022) included a focus of "Difficulty making decisions, impaired decision-making related to dementia." Interventions include to engage in simple, structured activities that avoid overly demanding tasks. R6's Activities of Daily Living care plan (revised January 10, 2024) showed a February 4, 2022) intervention that showed "DRESSING: Requires substantial [assist] of 1 staff participation to dress." There is no evidence that showed R6 is able to consent to any sexual activity.

On January 19, 2024 at 12:40 PM, R6 was sitting in the dining room. When asked, R6 introduced herself and said she was 19 years old and then her speech became unintelligible. R6 was able to stand up and walk without staff assistance.

R7's Admission Record showed he was admitted to the facility on December 1, 2023 with diagnoses of liver abscess and urinary tract infection. A diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance was added on January 9, 2024. R7's December 5, 2023 MDS showed he was severely cognitively impaired.

On January 11, 2024 at 12:03 PM, V10 (CNA) stated she had worked in the locked memory unit

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on January 8, 2024 and was on break when R6 and R7 were found in R7's room. V10 stated the nurse did not tell her what had happened but told her to keep an eye on R7. V10 stated she had never received report about R7 sleeping in another resident's bed or to continue monitoring for the behavior.

On January 11, 2024 at 01:09 PM, V7 (R7's POA-Power of Attorney) said on January 8, 2024, she was told R7 was caught attempting to have sexual intercourse with a female resident. V7 said R7 had dementia and would only be able to identify himself and close family members. V7 said this was the second incident that was reported to her, with the first occurring on December 24, 2023 where she was told by V5 (LPN) that he had found R7 attempting to have sexual intercourse with R6. V7 said when she came to the facility after Christmas Eve, V5 pointed out R6 to her. V7 said she was told for the first incident, V5 found R7 taking his pants off. V7 said when she was notified of the second incident, she was told by staff that R7 was pulling his pants up. V7 said after the second incident on January 8, 2024, she was told the facility was increasing R7's medications and adding an estrogen-based medication to lower his testosterone. V7 said the social worker told her they were labeling R7 as hyper-sexual due to the two incidents. R6's Family was unable to be reached during the survey.

Prior to the January 8, 2024 incident, R7's December 24, 2023 V5's (LPN/Licensed Practical Nurse) nursing progress note from 8:43 PM (23 days after R7's admission) showed "Resident climbed into another female resident bed to sleep while she was in bed. Resident was educated that he [cannot do] that. Resident got agitated

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with the nurse screaming to the nurse to get out. Nurse [calmed] down resident and got him out of the room. [V7, R7's POA] notified of resident behavior."

On January 10, 2024 at 2:28 PM, V5 LPN (Licensed Practical Nurse) stated there was one time he found R7 sleeping in another resident's bed, stating it was R10's bed. V5 stated he "didn't take it as anything ...most of them go sleep on somebody else's bed- it's a dementia unit, but I did chart it." V5 said he did not notify R10's POA. R10's December 24, 2023 progress notes showed no specific mention of the event, and instead showed a December 24, 2023 entry from 8:39 PM that showed "Nurse called [local] hospital to follow up with resident and was told the resident is been admitted. However, the receptionist could not give diagnosis." R10's and R6's Census in their EMRs showed R10 and R6 shared a room prior to R10's discharge. No documentation was present in either R6's or R10's progress notes regarding the December 24, 2023 incident.

On January 11, 2024 at 12:20 PM, V5 was again asked about the incident on December 24, 2023 where R7 was in R10's bed. V5 stated he notified R7's Power of Attorney (POA) and the Social Workers and he did not talk to R10's POA. V5 stated he told the on-coming night shift agency nurse to monitor him, but not about what happened, adding "I didn't see it as any big issue." V5 stated "I said to keep an eye on him because he might go sleep in someone else's bed."

On January 11, 2024 at 12:40 PM, V32 (Social Services) said she was told R7 wandered frequently and went into another resident's room

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and got into another resident's bed on Christmas Eve. V32 said she was told R7 was the only one in the room and she updated R7's care plan. V32 said R7 is more agitated in the evenings and interventions were for staff to monitor him and to redirect him into activities. V32 said the next incident she had heard was from January 8, 2024 when R7 was found halfway unclothed with R6. V32 said there had been miscommunication about what happened on Christmas Eve and she had only read the progress note on January 10, 2024, and she did not know who that resident was from the earlier incident. V32 stated if R7 had the behaviors, he should have been more closely monitored so the incident on January 8, 2024 would not have occurred. V32 said residents on the memory care unit for the most part are not able to make decisions for themselves, including R6 and R7. V32 said when she read R7's progress notes from December 24, 2023 and January 8, 2024, they were different stories than what she had received. V32 said it was not made clear that R7 was climbing into bed with another resident already in the bed, and if she had known, a room change would have been done on December 24, 2023.

R7's Behaviors care plan (initiated December 28, 2023, four days after the incident with R10 and written by V32, Social Services) showed "On occasion, [R7] is seen displaying inappropriate behaviors such as climbing into other residents' beds. As well as yelling/screaming at staff." Goals include attempting to follow staff redirections and refraining from going into other resident rooms and beds. The only intervention listed is "[Interdisciplinary Team] will monitor," which was revised on January 16, 2024 (during the survey), from "[Social Services] will monitor."

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R7's December 26, 2023 Nurse Practitioner (NP) progress note showed "Nurse reported some behavior concerns/agitation. Patient went into another resident's bed the other night and was removed by staff. In house psych to follow- agitation in hospital and had been on Seroquel ...Nurse reports overnight patient agitated removing clothes and wandering hall."

On January 11, 2024 at 02:45 PM, V14 (Psychiatric NP) said he saw R7 for the first time on January 8, 2024 for hyper-sexual behaviors and Alzheimer's dementia with behavioral disturbances. V14 said the staff told him R7 made a lot of sexual comments and would speak to females in a flirtatious manner. V14 said he went to the facility on January 8, 2024, and the staff told him they had caught R7 attempting to perform some type of sexual activity with a female resident. V14 said when he came to evaluate R7, he saw R7 speaking to a female CNA and could tell R7 was flirting with her. V14 said R7 should not be left alone with female residents. V14 stated he increased R7's antidepressant medication to reduce his sexual behaviors.

On January 18, 2024 at 02:10 PM, V14 said he would expect the staff to report resident behaviors to the NP or the Physician- behaviors like going into other residents' rooms, sexual acts, groping, being sexually threatening, making sexual comments or specific comments about a resident's breasts or genitalia, taking one's clothes off in public places, touching their own genitalia in public places, having an erection in the middle of interacting with someone, and climbing into another resident's bed with another resident in the bed. V14 said if a resident appeared to be fixated on another resident, he

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would have told the staff to keep monitoring the resident and to separate them from one another. V14 said he was not notified R7 had climbed into another resident's bed on December 24, 2023. V14 said if he had known of the incident on December 24, 2023, he would have increased R7's psychotropic medications then and ordered behavioral monitoring to ensure he was not left alone with female residents. V14 said the residents on the memory care unit cannot make decisions for themselves, and none of them would be able to consent to sexual contact.

On January 11, 2024 at 11:42 AM, V13 (CNA) stated staff monitor R7. V13 stated she never received any instructions about R7. V13 stated R6 is always sitting in the dining room, and she will ask staff to use the bathroom. V13 stated she has never seen R6 have any inappropriate behaviors with other residents. V13 stated when she came back to work after Christmas, she was told she "needed to watch [R7]." V13 stated "they said something happened, but I don ' t know what."

The facility's January 12, 2024 final IDPH Reportable Event for the January 8, 2024 abuse allegation notification showed "...Investigation shows that both residents [R6 and R7] had no malicious intent towards each other ....there would not have been any time for either resident to have touched each other in any sexual manner ....It is obvious to staff that they had a liking to each other, took a walk and may have wanted a nap as husband and wife ...The allegation of sexual abuse is unsubstantiated ..."

The facility's "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" policy (revised November 1, 2021) defined Sexual

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abuse as "non-consensual sexual contact of any type with a resident."

The facility's 11/01/2021 Abuse Policy showed "It is the policy of [Facility] that each resident will be free from 'Abuse.' Abuse can include ...sexual ..... No abuse or harm of any type will be tolerated, and residents and staff will be monitored for Protection ..." Under "Resident Assessment" in the "Procedure" section, the policy showed "Every resident is unique and may be subject to 'abuse' based on a variety of circumstances, including ...the resident's health, behavior, or cognitive level ..." Under "4. Population," the policy showed "a. The facility's population presents the following factors, which could result in maltreatment of residents: The assessment, planning of care and services, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of cognitive deficits, sensory deficits, aggressive behaviors, residents who have behaviors such as entering other residents' rooms, wandering behaviors ...socially inappropriate behaviors, verbal outbursts, residents with communication disorders, those who are nonverbal ...b. The facility will ensure a comprehensive dementia management program to prevent resident abuse ..." Under "Identification," the policy showed "...It is the policy of this facility that all staff monitor residents and will know how to identify potential signs and symptoms of "abuse." Occurrences, patterns, and trends that may constitute "abuse" will be investigated ..."

(A)