Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006647	A. BUILDING: ______ B. WING ______	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE WAUKEGAN	2222 WEST 14TH STREET WAUKEGAN, IL 60085

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S 000	Initial Comments Complaint Investigation 1917107/IL116104 1917140/IL 116145 Facility Reported Incident 9/24/19/IL116111	S 000		
S9999	Final Observations Licensure Violations 300.610a) 300.1210b) 300.3240a) 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 300.1210 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	S9999		

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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.

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.

Theses regulations were not met as evidenced by:

Based on interview, and record review the facility failed to protect a resident (R5) from sexual abuse and two residents (R2, R4) from verbal abuse for 3 of 6 residents reviewed for resident to resident abuse in the sample of 6.

The findings include:

1. The facility's Preliminary 24-hour Incident Investigation Report showed on "On 9/24/19 (Date is incorrect. Incident was faxed to the Local State Agency on 9/23/19) at around 11:15 PM it was reported to the Administrator that one of the Nurses had witnessed (R6, male) touch (R5,

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female) inappropriately by the nursing station..."

The facility's investigation showed a 9/25/19 statement from V11 Licensed Practical Nurse (LPN) as follows, "I witnessed (R6) and (R5) sitting next to the Nursing station having a conversation. I looked down for no longer than 30 seconds and (R6) had his hand on (R5) and was touching her inappropriately..."

On 9/26/19 at 10:05 AM, V11 stated he observed R6 with one of his hands under R5's gown. V11 denied being aware of any inappropriate sexual behaviors regarding R6. V11 stated, "I haven't been on that floor a lot...I am not aware of any behaviors he (R6) has...I was not aware of any previous sexual behavior. I've never heard of him making inappropriate comments to staff or residents."

V17 Local Police Department Officer summary statement showed, "On 09-23-19 at approximately 2314 hours (11:14 PM), I (V17) responded to (the facility)...in reference to a sexual assault between 2 patients. Upon my arrival, I met with the facility administrator (V1) and nurse (V11) . (V1) informed me that a dementia patient had touched the vaginal area of another patient who is diagnosed with congestive heart failure and diminished mental capacity. (V1) Informed me that the offender, (R6) has a history of making inappropriate sexual remarks towards other patients...(V1) informed me that (V11) witnessed (R6) touching the vaginal area of (R5) earlier...(R5) appeared to have the speech pattern of a young child, but did state that (R6) tries to touch her breasts often. (R5) stated that she repeatedly tells him to leave her alone which he does not comply with. (R5) stated that her and (R6) are not and have never been in a

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relationship with each other. (R5) stated she remembered (R6) touching her today, but did not state where he touched her. (R5) stated she tells him to stay away from her vagina and does not let him touch her there. (R5) stated she wanted (R6) arrested for bothering her and trying to touch her breasts...V11 stated that today, while he was charting at the main nurses station on the 4th floor both (R5) and (R6) were sitting near each other. (V11) stated that he had to turn away for a moment and when he returned he saw (R6's) hands under (R5's) gown in the area of the vagina...we returned to (V1's) office where I learned that they had reported a similar incident earlier this year between (R6) and another female patient..."

On 9/25/19 at 10:30 AM, the facility's 9/23/19 security footage was reviewed, with V1, for the fourth floor nursing station. The video showed at 7:39 PM (V1 stated the date and time stamp was accurate) V11 sitting at the nurses station. To V11's right, R5 was sitting in a chair in the hallway and she was facing V11. V11 appeared to be looking down at the desk. At approximately 7:40 PM, R6 was observed self propelling in a wheelchair towards R5. R6 moved to a position directly in front of and facing R5. V11 did not intervene when he moved in front of her. In the camera angle, R5 is facing the camera and R6 had his back to the camera. R6's position obscured vision of R5's lower half and where he was placing his hands. Shortly after R6 maneuvered his chair in front of R5, he leaned towards R5. At approximately 7:42 PM, V11 looked around the nursing station desk, stood up, and separated R6 from R5.

On 9/25/19 at 10:45 AM, R5 stated, in regards to the 9/23/19 incident, "(R6) touched me all over."

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R5 said, "It felt terrible. I'm scared of him. He touched me at the nurses station."

On 9/25/19 at 11:10 AM, V14 Certified Nursing Assistant stated R6 likes to grab females in the chest and bottom. V14 stated, "He does it as often as he wants when he thinks no one is watching...He's had those behaviors as long as I've worked here." V14 stated, she has worked at the facility for approximately one year.

On 9/26/19 at 1:45 PM, V17 stated during his interview of R5 he had no reason to believe R5 was fabricating her recollection of the incident on 9/23/19; "I had no reason to not believe her. She answered matter of factly and did not pause during her statement like she was formulating a plan."

The facility's Preliminary 24-Hour Incident Investigation Report showed R6 was involved in previous resident to resident incident. The report dated April 7, 2019 showed "staff has witnessed resident (R6) allegedly touched (R10) inappropriately on the top of her clothing..."

The facility's investigation showed a statement taken on 4/7/19 by V1 from a facility staff member as follows, "...(R6) approached (R10) in the hallway and touched her inappropriately on top of her clothes in her private areas..."

R6's Care Plan created on 12/18/17 and revised on 9/24/19 showed, "(R6) exhibits sexually inappropriate behavioral symptoms as manifested by making crude, sexually-oriented and/or suggestive remarks towards females...these symptoms may be related to dx of mild cognitive impairment and poor impulse control..." The care plan showed an intervention

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initiated on 9/24/19, "Resident will be admitted to a (local area hospital) for evaluation of sexually inappropriate behavior towards a female resident..."

R6's 8/23/19 Psychiatry/Mental Health note showed, "Patient was seen this morning due to behavioral disinhibition. Per medical staff, patient continues to make derogatory statements towards staff and other residents. Difficult to redirect. Verbally inappropriate..."

The facility's Abuse Prevention and Reporting police revised on 1-22-19 showed, "The resident has the right to be free from sexual abuse..." The policy continues, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish...Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...Sexual abuse is non-consensual sexual contact of any type with a resident.

2. The facility assessment dated 7/16/19 shows R2 is alert and oriented.

On 9/24/19 at 12:43 PM, R2 said that on 9/20/19 around lunch time while waiting to ride in the elevator, a male resident (R3) threatened to hit her. R2 said R3 also called her a name " fuxx-ing fat." R2 said she reported the incident to V9 (Social Worker) and V1 (Administrator) when the incident happened. R2 said nothing has been done to R3 going around verbally abusing residents. R2 said R3 was also verbally abusive

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to R4.

On 9/25/19 at 10:15 AM, R3 (alert and oriented per facility assessment dated 7/31/19) when asked about R2, R3 stated, "That fat lady tried to ride with me in the elevator? Yes I called her fat! Why?"

On 9/25/19 at 12:11 PM, V9 said R2 reported to her that last Friday (9/20/19) R2 was down by the elevator and R3 made inappropriate comments to R2. V9 said it was concerning enough that V9 reported the incident to V1. V9 said V1 is the abuse coordinator of the facility.

On 9/25/19 at 2:15 PM, V1 (Administrator) said there was no investigation done regarding R2's allegation of R3 being verbally abusive.

The facility's Abuse Prevention and Reporting policy revised on 1/22/19 showed, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation...It includes verbal abuse..."

3. The facility assessment dated 8/1/19 shows R4 is alert and oriented. R4 has cerebral palsy and is legally blind.

On 9/24/19 at 12:40 PM, R4 said he was blind and would at times bump into R3. R4 said R3 punched him in his upper arm a couple of months ago. R4 said he reported the incident to V9 (Social Worker). R4 also stated "{R3} call me names, threatens me, I can't help it. At times I do bump into him but that does not give him the right to hit me or call me names."

On 9/24/19 at 2:10 PM by the 2nd floor nurses station, R8 and R9, both said R3 is really mean to

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R4. R3 calls R4 the "N" word and nothing is being done about it. Both R8 and R9 said they feel sorry for R4.

On 9/25/19 at 10:15 AM, R3 stated "I threatened him (R4) He kept bumping into me, he better stay away from me."

On 9/25/19 at 12:11 PM, V9 (Social Worker) said she cannot recall anything specific relating to R3 and R4.

On 9/25/19 at 2:15 PM, V1 said R3 acts like that due to his cognition. (Facility assessment shows R3 is alert and oriented)

(B)