STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002695	A. BUILDING: _____ B. WING _____	C 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK RIVER GARDENS	3601 SIXTEENTH AVENUE STERLING, IL 61081

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S 000	Initial Comments FRI of 2/21/2020/IL120624 - F600 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a)f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

includes measurable objectives and timetables to 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)

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. Restorative measures shall include, at a minimum, the following procedures:

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator,

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	IL6002695	A. BUILDING: _____ B. WING _____	C 03/11/2020

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S9999	Continued From page 2	S9999		

employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

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. (Section 3-612 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident at risk for abuse was free from sexual abuse for 1 resident (R1) reviewed for abuse. This failure resulted in R1 responding physically agressively toward (R22).

The findings include:

R1's medical record showed R1 was a 25 year old female. R1's medical record showed R1 was admitted to the facility on December 4, 2017 with diagnoses to include major depressive disorder, schizoaffective disorder and intellectual disabilities.

R1's acute behavioral healthcare hospital discharge paperwork signed July 1, 2019 showed R1 had a history of physical, sexual, and emotional abuse.

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S9999	Continued From page 3	S9999		

R1's complete current care plan was reviewed and showed no interventions to protect her against unwanted sexual advances, did not include her history of sexual abuse, and did not include any information regarding her violent reaction to unwanted touching, perceived sexual advances, or sexually inappropriate comments made by male peers.

On March 3, 2020 at 8:50 AM, R1 was ambulating independently through the halls. R1 was not making eye contact with the other residents in the hall and walked from one end of the facility to the other at a rapid pace repeatedly. This surveyor approached R1 and requested to speak with her. R1 walked down to her room which was located one room from the end of the hallway. R1 said she was upset by something that had happened. R1 reported that she was sleeping when [R2] came into her room and laid in her bed with her. R1 said R2 began rubbing her back and legs and kissed her on the mouth. R1 said she tried to get him out of her room but R2 would not leave. R1 said she felt uncomfortable and did not want R2 touching her. R1 said R2 told her he was going to sleep next to her and then asked if she has had an orgasm. R1 explained a history of sexual assault to this surveyor and said it makes her feel very uncomfortable when she is touched by other residents.

The facility investigations for resident to resident incidents were reviewed and showed three incidents of sexually inappropriate behavior involving R1.

1. The facility's investigation into an incident which occurred on February 21, 2020 between R1 and R2 showed R2 touching and speaking to R1 in a sexually inappropriate manner which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002695	A. BUILDING: _____ B. WING _____	C 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 4	S9999		

resulted in R2's transfer to a behavioral health hospital. The investigation showed R11 and R23 both reported R2 coming into their rooms uninvited in the past.

R1's nursing progress note dated February 22, 2020 showed, "[R1] has made allegation of inappropriate touching against a male resident..."R2's nursing progress note dated February 22, 2020 showed, "Allegation of inappropriate touching made against resident by another female resident. [R2] immediately placed on one to one status..." R2's nursing progress note dated February 26, 2020 showed R2 was transported to an acute behavioral health hospital.

On March 4, 2020 at 11:35 AM, R23 said R2 has come into her room in the past and tried to kiss her. R23 said she told him she did not like him doing this and to stop.

On March 4, 2020 at 3:06 PM, V9 CNA (Certified Nursing Assistant) said R2 has been known to go into other resident rooms. V9 said R1 had reported to her that R2 got in her bed and was rubbing her back and kissed her. V9 said R2 has a crush on another female resident and goes into her room uninvited a lot and she will yell at him and tell him to go away.

R2's face sheet showed he was admitted to the facility on November 1, 2014 with diagnoses to include schizoaffective disorder, obsessive compulsive personality disorder, and bipolar disorder. R2's complete current care plan was reviewed and showed, "[R2] has behaviors of being intrusive to others. He will go into the rooms of other residents, he will obsess over the needs of others and cause conflict.ns." R2's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 5	S9999		

plan does not identify any sexually inappropriate behaviors or statements and does not include any interventions for sexually inappropriate behaviors. R2's care plan does not address entering other resident's rooms uninvited. R2's nursing progress notes from October 2019 through current showed R2 has been difficult to redirect, intrusive to other residents, and has been entering other resident rooms uninvited multiple times.

2. The facility's investigation into an incident which occurred on February 14, 2020 showed a staff member heard R1 yelling "Don't touch me, get away" and witnessed R3 trying to kiss R1 and reaching for R1's breasts resulting in R3's transfer to a behavioral health hospital.

R1's nursing progress note dated February 14, 2020 showed, "[R1] was walking down the hallway when another resident grabbed her inappropriately.." R3's nursing progress note dated February 14, 2020 showed, "[R3] was observed inappropriately touching another female resident..."

R3's face sheet showed he was admitted to the facility on January 4, 2017 with a diagnosis of Schizoaffective disorder. R3's care plan showed a behavior care plan initiated on June 17, 2019. (No interventions had been added since June 17, 2019) This care plan showed, "Resident is known/has history of displaying inappropriate boundaries with staff members." R3's care plan did not address any sexually inappropriate behaviors or inappropriate boundaries toward other residents.

3. The facility's investigation into an incident which occurred between R1 and R22 on September 23, 2019 showed R22 was heard by

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	IL6002695	A. BUILDING: _____ B. WING _____	C 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 6	S9999		

staff making sexually inappropriate comments to R1 causing her to react violently and resulting in R22 being transferred to a behavioral health hospital.

R1's social services progress note dated September 23, 2019 showed, "[R1] reported that a male resident [R22] was making inappropriate comments towards her... she told him to stop and leave her alone but the male resident continued... [R1] also said she wanted to speak to someone about her past of 'being touched' ..." R22's nursing progress note dated September 23, 2019 showed, "Resident was heard sexually harassing another resident... they were immediately separated and [R22's] sexual comments and verbally inappropriate comments became worse... for resident and other residents safety the resident was going to need to be sent out for evaluation..." R22's social service note dated September 23, 2019 showed, "[R22] was upsetting a female resident by saying things to her about sexual contact... [R22] said 'oh you want him to molest you again'... [R22] was sent out for an evaluation..."

The facility's investigation in to the incident that occurred between R1 and R22 on September 23, 2019 showed a staff member had heard arguing in the hallway. When the staff member responded to the area she overheard R22 making sexually inappropriate comments to R1. R1 began arguing back and in the moment was unable to control herself and made physical contact with R22's chest. During the facility's investigation R1 was interviewed and said she tried to hit R22 in the face. R1 said R22 pushed her and she hit him in the chest. R22 was unable to be calmed down and this incident resulted in R22 being sent to an acute behavioral hospital for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 7	S9999		

evaluation.

R22's nursing progress note dated September 23, 2019 showed, "Resident was heard sexually harassing another resident. He pushed the other resident too far with his comments and she swung and made contact twice. It was once on his chin/chest and his chest the second time..."

R22's social services progress note dated September 23, 2019 showed, [R22] was upsetting a female resident [R1] by saying things to her about sexual contact... This is when the female turned around and punched him in the face..."

R1's social services progress note dated September 23, 2019 showed, "[R1] reported that a male resident [R22] was making inappropriate comments towards her... she told him to stop and leave her alone but the male resident continued and [R1] turned around and started hitting him..."

R22's face sheet showed he was admitted to the facility on October 18, 2018 with a diagnosis of Schizoaffective disorder. R22's complete current care plan was reviewed and showed a care plan initiated on May 6, 2019 which showed "Resident displays inappropriate behaviors and verbal aggression, inappropriate language, and sexual comments toward staff..." with one intervention added since its initiation. The care plan showed an intervention added on October 20, 2019 which showed, "Be firm and remind [R22] that those types of comments are inappropriate and that he needs to stop. Redirect him to another area away from others." The care plan did not address sexually inappropriate behaviors directed toward other residents.

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S9999	Continued From page 8	S9999		

On March 5, 2019 at 10:02 AM, V7 (Social Services Director) and V8 (Psychiatric Rehabilitation Services Coordinator) were interviewed together. V7 said she was aware of the incident that occurred between R1 and R2. V7 said R1 reacts violently to sexually inappropriate touching and responds quickly and defensively. V7 said this reaction is because R1's brother had touched her inappropriately when she was a young child. V8 said during a counseling session R1 told her she was raped in the past. V7 said R2 told her he did go into R1's room. V7 said R2 does go into other residents rooms and she has had to talk with him about this. V7 said R2 likes to go into another resident's room and watch her sleep. V7 said in order to protect R1 from R2 she feels that staff would have to be with him at all times, to protect R1 from R3 they are discussing starting him on birth control shots to decrease his sexual drive, and to protect R1 from R22 they have had conversations with him reminding him not to touch or speak inappropriately to other residents.

The facility's abuse prevention policy dated February 2020 showed, "...this facility affirms the right of our residents to be free from abuse... This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, 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 ... establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect and abuse of residents... Identifying occurrences and patterns of potential mistreatment, exploitation, neglect, and abuse of

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	IL6002695	A. BUILDING: _____ B. WING _____	C 03/11/2020

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ROCK RIVER GARDENS	3601 SIXTEENTH AVENUE STERLING, IL 61081

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S9999	Continued From page 9	S9999		

residents... sexual abuse is a non-consensual sexual contact of any type with a resident... Resident Assessment. As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis..."

The facility's resident council meeting minutes were reviewed and showed in December 2019 and January 2020 concerns were discussed with residents going into other resident rooms without permission.

(B)