

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2020
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NAME OF PROVIDER OR SUPPLIER HILLTOP SKILLED NSG & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST POLK STREET CHARLESTON, IL 61920
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S 000	Initial Comments Complaint Investigation 2062895/IL122032 2063941/IL123126 2063942/IL123127	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)3) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</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>These requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure that two (R1, R4) residents were free from sexual abuse, perpetrated by residents (R2, R5). R1 and R4 are two of four residents reviewed for resident to</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>resident sexual abuse in a sample list of 15 residents. This failure caused R4 to experience physical trauma (vaginal bleeding) and psychosocial trauma including tearfulness and fear following the incident with R5.</p> <p>This failure also caused another resident, R1 to experience psychosocial trauma including feeling violated, embarrassed, and angry following the incident with R2.</p> <p>Findings include:</p> <p>1. R4's Order Summary Report printed 7/22/20 includes the following diagnoses: Alzheimer's Disease with Early Onset, Major Depressive Disorder, Cognitive Communication Deficit and Chronic Obstructive Pulmonary Disease.</p> <p>R4's Minimum Data Set (MDS) dated 4/16/20 documents R4 is cognitively impaired.</p> <p>R4's Summary of Investigative Findings dated 5/8/20 states "At approximately 1:15 PM V1 Administrator was notified by the nurse (V3), Licensed Practical Nurse (LPN) of an allegation of resident to resident abuse between R4 and R5." There is no documentation by V3 in the progress notes.</p> <p>R5's Order Summary Report printed 7/22/20 includes the following diagnoses: Chronic Obstructive Pulmonary Disease, Arteriosclerotic Heart Disease, Major Depression, and Alcohol Abuse.</p> <p>R5's Minimum Data Set (MDS) documents R5 as moderately cognitively impaired. R5's Care Plan documents "R5 has impaired cognitive function/dementia or impaired thought processes</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>r/t (related to) Difficulty making decisions, Alcohol Dependence with Withdrawal Delirium so R5 tends to forget things."</p> <p>There is no mention of sexually inappropriate behaviors in R5's Care Plan or other documentation.</p> <p>There is no documentation in R4 or R5's medical record that there has ever been a history of consensual sexual or physical relations between R4 and R5.</p> <p>On 7/21/20 at 1:00 PM V3 (Licensed Practical Nurse/LPN) stated "On 5/3/20 at around 1:00 PM R4 was walking down the hall crying and looked really upset. I approached R4 and asked her what the matter was. R4 stated 'R5 came in my room and put his whole fist in my vagina. I didn't want him to and now I went to the bathroom and I'm bleeding down there.' R4 has mild dementia, but she very well knew what was going on. I immediately called V1 (Administrator). V1 came in and called the police and the family, and we sent R4 to the hospital. I made a written statement to V1 and V1 took care of the documentation since V1 is the abuse coordinator."</p> <p>On 7/20/20 at 11:00 AM V1 stated "R4 reported to (V3) on 5/3/20 R4 had some vaginal bleeding after R5 put four fingers in R4's vagina. R4 stated that she didn't want R5 to touch her but R5 did. I believe R4 because R5 had dried blood on R5's knuckles and cuticles. The police were called and at first R5 stated it was consensual but then admitted R5 had touched R4's vagina with R5's fingers. R5 was arrested and is still in the county jail. R4 went home with a care giver after being at the hospital for a rape kit to be done. R5 stated</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>the contact had occurred sometime after dinner 5/2/20." V1 denied there was ever any other sexually inappropriate behavior observed from R5 prior to this incident. V1 stated "R5 was helpful to other residents and even pushed other residents in wheelchairs sometimes. We had no reason to believe R5 would have done this. R4 and R4's family are the nicest people. R4's husband was even here for a while. R4 was content and visited with staff and other residents. There had not been anything between R4 and R5 until this."</p> <p>On 7/22/20 at 1:47 PM V11 (Power of Attorney for R4) stated "R4 is at home with family and a care giver now. R4 was crying at the hospital. R4 talked about what happened for a while but hasn't for a few days. I believe R4's dementia worsened after R4 went through the abuse and had to have the rape kit at the hospital. R4 was very upset at the hospital and when R4 was questioned by the police. R4 cried on and off for a while. I think it would happen again if it is brought up to R4. It has also been hard for R4 to get used to being at home. The routine at (the facility) was good for R4 and it took R4 a while to get used to a new routine. R4 is married and (R4's husband) is still living. R4 would never have done anything like what happened if it were up to R4. R4 was a happy person. R4 has had depression for years, but R4 knows when R4 is sad and asks for something to do like help around the house and when R4 is occupied it take R4's mind off the sadness."</p> <p>On 7/25/20 at 9:58 AM V14 (Rape Crisis Counselor contracted by local hospital) stated "I was called into the emergency room (5/3/20) when the rape kit was being done on R4. R4 is in the early stages of dementia so some details like exact time it happened were not clear, but what</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>was consistent with every person who interviewed R4 was a male she knew inserted fingers into R4's vagina and then R4 had some vaginal bleeding. I do believe R4 knew what happened and I believe R4. Sometimes the trauma of a situation like that can get confused even in a person without dementia. R4 was tearful at times and very upset and frightened."</p> <p>On 7/22/20 at 11:00 AM V13 (Registered Nurse/RN) who is the emergency room nurse who assisted R4 on 5/3/20 (when the rape kit was done) stated "R4 did cry at times when R4 talked about what happened. R4 was consistent in the statement that R5 had inserted R5's hand into R4's vagina and that R4 had bleeding from her vagina. The rape kit is traumatic too. I am convinced that something happened to R4 and it did emotionally upset her."</p> <p>On 7/23/20 at 9:03 AM V22 (a detective who works with sexual assault cases for the police department) stated "I am reading the report from 5/3/20. R5 had blood around R5's cuticles on one hand. We took samples. R4 had blood on her clothing that was sent to the state police lab. At first R5 stated it was consensual and R5 did not penetrate R4. But when R5 was asked about the blood on R5's fingers, R5 admitted that R5 had inserted R5's index and middle fingers into R4's vagina and R4 was bleeding. R5 stated this had happened sometime the evening of 5/2/20."</p> <p>2. R1's Order Summary Report printed 7/22/20 includes the following diagnoses: Alzheimer's Disease, Major Depressive Disorder, and Cognitive Communication Deficit. R1's Minimum Data Set (MDS) dated 3/5/20 documents R1 as moderately cognitively impaired.</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>R1's Care Plan dated 5/11/20 states "This resident has the potential for abuse/neglect due to Depression diagnosis, Inappropriate behaviors affecting others - such as provoking, disrespectful actions or comments, attention seeking outburst, Invading other's space and property, Rummaging through belongings or wandering in and out of other's spaces, Physical vulnerability such as poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, Underlying factors that increase vulnerability, including dementia, confusion, poor judgment, wandering and giving away personal property."</p> <p>R2's Order Summary Report printed 7/22/20 includes the following Diagnoses: Dementia and Major Depressive Disorder.</p> <p>R2's Care Plan updated 4/29/20 documents "Resident is sexually inappropriate and masturbating in public areas r/t (related to) Dementia. Staff reports that patient was noted standing over his roommate masturbating, patient does not recall event. Resident will also yell from his room stating that he needs his (slang for penis) sucked. Resident does not recall saying any of it."</p> <p>R2's care plan history from 2/16/17 until 2/5/20 documents R2's "public masturbation" was first identified 11/2/16 "standing over R2's roommate masturbating" was added to the care plan on 2/12/17.</p> <p>A Care Plan problem statement related to R2 documents, "yell from R2's room R2 'needs his d*** (penis) sucked'" was added 3/14/19.</p> <p>From 2/16/17 until 7/27/20 during this escalation of R2's sexually inappropriate behavior the only</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>interventions documented were to take R2 to his room if seen masturbating in a public area and make sure the door is shut if R2 is in room. There was no documentation of how other residents were to be protected from R2's behavior.</p> <p>On 7/26/20 at 2:48PM V12 (Care Plan Coordinator) verbalized in looking back on the care plan history, the facility has been aware of R2's disrobing and masturbating in common areas of the facility "since 2016." On 7/27/20 at 1:15PM V12 stated "As far as I know the only interventions we have had are to take R2 back to his room and make sure the door is shut."</p> <p>R2's medical record documents the following aberrant sexual behaviors:</p> <p>R2's SBAR (Situation, Background, Assessment, Recommendation) report dated 2/12/17 documents "R2 was seen standing over roommate, while roommate was in bed, masturbating." The Licensed Practical Nurse who signed this report is no longer employed by the facility and is not available for interview. On 7/27/20 V1 verbalized the roommate referred to has since died.</p> <p>V38's (Psychiatrist) evaluation dated 11/19/17 documents "R2 was seen at the nursing home 11/19/17 due to frequent self-masturbation. Unfortunately R2 does this in the hallway in front of staff and other patients. Attempt to redirect to his room frequently is not successful. R2 also walks around in the hallway naked. When attempted to redirect patient states "I can walk around naked anytime I want to." There is no documentation included in R2's medical record of psychiatric follow-up after this evaluation.</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>Record review documents the following:</p> <p>On 8/31/18 V40 (LPN) documented in a progress note R2 told a Certified Nurse's Aide to "suck my (penis)." On 3/18/20 V40 documented R2 was "sitting in the hall masturbating."</p> <p>Social Service Assessments dated 12/27/16, 7/25/18, 3/14/19, 6/4/19, 8/23/19, and 11/22/19 all include notes describing R2's frequent masturbation in common areas of the facility with other residents present and sexual remarks to staff.</p> <p>On 7/27/20 at 1:11PM V4 (LPN) stated that on 4/12/20 "R1 said you gotta get me out of this room. R2's a q*** (derogatory). R2 tried to j*** (sexual reference) me off and I had to push him off me. It was a Sunday. I know I talked on the phone with V1 about this."</p> <p>On 7/27/20 at 2:10PM V43 (Certified Nurse's Aide/CNA) stated "R2 plays with himself all the time. They have moved a couple roommates out because of that. I can't remember who. On (4/12/20) R1 put his light on. I went into the room and R1 said 'Get me the f*** (expletive) out of this room.' I asked why and R1 told me R2 had asked R1 to suck his d*** (penis). R1 said that R2 had touched his penis." V43 verbalized that she was sure she had called V1 and told V1 about this incident.</p> <p>On 7/26/20 at 3:35PM V40 (LPN) stated "R2 makes sexual comments and frequently masturbates where other residents see it, like in the hall or the dining room. Basically, R2 wants to do whatever he wants and doesn't want to be messed with. We try to redirect him when we see it."</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>On 7/27/20 at 1:45PM V44 (CNA) stated "R2 touches himself a lot. I've seen him do it in the dining room with other residents there. I have heard R2 tell R1 to suck his d***(penis). Last night (7/26/20) R2 went into the hall naked. If R2 is dressed he will put his hands in his pants and masturbate. He doesn't care who sees."</p> <p>On 7/27/20 at 1:50PM V45 (CNA) stated "I work down East hall (where R2's room is) most of the time. R2 cusses a lot and he likes to be naked. A couple of months ago I saw R2 masturbating in the dining room with other residents there. I took him back to his room."</p> <p>On 7/27/20 R15 (a resident identified by V1 as "interviewable") stated "I've been here about nine months. There is a guy who just sits in the dining room or wherever else he happens to be and plays with himself. I don't want to see that, so I eat in my room and now we mostly do anyway." When asked exactly R15 meant by "plays with himself" R15 verified R2 "masturbates."</p> <p>On 7/27/20 at 12:45PM V21 (LPN) verbalized that she was aware of R2's frequent masturbation in common areas. "R2's masturbated in the halls and the dining room with other residents. I am aware that R2 has stood over another resident and masturbated. R1 is truthful and knows what goes on. I would believe R1."</p> <p>On 7/21/20 at 3:33PM V4 (LPN) stated "(4/12/20) I went in R1's room to give medications and R1 said 'I need to get out of this room. My roommate R2 (masturbated) me. I'm not a (derogatory term for homosexual male) and I didn't want it and I don't want to be around R2.' I immediately called V1. I don't think I documented anything because</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>V1 is the abuse coordinator and V1 took over from there." When asked if it was V4's impression that R1 was telling her R1 was touched against R1's will by R2, V4 stated "Definitely, I have known R1 since I was a kid and I think R1 was angry and wanted out of that room. R1 said it happened that day (4/12/20)."</p> <p>R1's Grievance/Complaint Resolution Report dated 4/12/20 documents "R1 reported to nurse R1 wanted out of room because R2 was a (derogatory term for homosexual male) and R2 asked R1 to sexually gratify R2." V1 denied an investigation was done concerning this because "I talked to R1 and R1 denied any contact. I did not consider it abuse." V1 identified the "nurse" referred to on the grievance as V4 (Licensed Practical Nurse/LPN). No documentation of this occurrence is present on R1's or R2's medical record.</p> <p>On 7/20/20 at 11:00am when asked why R1's request for a roommate change was not addressed V1 stated "R1 denied it and I didn't hear anything more about it. R1 was in the room with R2 until 7/11/20 when he was moved to an isolation room because of a respiratory infection."</p> <p>On 7/20/20 at 11:55AM R1 was lying in his bed. When asked about the 4/12/20 incident with R2, R1 stated "I remember that. I can't say what date it was, but I told a nurse I trust. I was lying in bed and R2 came over to me; I was wearing a gown. R2 is always yelling about needing (oral sex). R2 plays with his (slang for penis) all the time. It's sick, but I got used to it. R2 came over by my bed in wheelchair and reached under my gown and started to touch me."</p> <p>When asked where R2 touched R1, R1 pointed to</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER HILLTOP SKILLED NSG & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST POLK STREET CHARLESTON, IL 61920		
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S9999	<p>Continued From page 11</p> <p>R1's groin. R1 stated "R2 (derogatory term for masturbation) my penis." When asked how it made him feel, R1 stated "I felt violated. I am not a (derogatory term for homosexual male). I have grabbed female staff. I like women. I was too embarrassed to tell too many people. I am not a (derogatory term for homosexual male)."</p> <p>When asked if R1 had told V1, R1 stated "No just the nurse I trust." At this time, R1 gave permission to have V1 come into room. V1 asked R1 if he had been touched inappropriately; R1 stated "Yes. R2 (derogatory term for male masturbation) me off. I didn't want to tell you. I told a nurse I trust. It (4/12/20 incident) was when I was over there in the other room before I got sick." When R1 was talking about this (4/12/20 incident) R1 cast his eyes down and looked at the wall. R1 nervously twisted the sheet around his fingers.</p> <p>On 7/27/20 at 1:10PM R1 was in his room eating lunch. R1 stated "I didn't tell V1 about it (the incident 4/12/20) because V1 was already mad at me for grabbing the girls b***s (breasts). I didn't want V1 to think I am a q**** (derogatory). I was embarrassed and I need to have a room here. I don't have any other place to go." R1 pushed his food around on the plate with his fork and avoided eye contact. R1 then stated "I'm glad I'm away from that q**** (derogatory)."</p> <p>(A)</p>	S9999		