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
	IL6013189	A. BUILDING: ____ B. WING ____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF MARYVILLE	6955 STATE ROUTE 162 MARYVILLE, IL 62062

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S 000	Initial Comments 2047697/IL127254 2048228/IL127826 2048362/IL127975	S 000		
S9999	Final Observations Statement of Licensure Violations Licensure finding 1 of 2 : 300.610a) 300.1210 b) 300.1220 b)2) 300.3240 a) 300.3240c) 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	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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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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

These requirements are not met as evidence by:

Based on observation, interview, and record review the facility failed to implement their Abuse policy by not reporting alleged sexual abuse allegations to the Administrator, not investigating alleged sexual abuse, not reporting alleged sexual abuse to the police and the survey agency, and not removing alleged perpetrators

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S9999	Continued From page 2 with dementia (R1 and R5) from direct contact with each other after several allegations of sexual abuse were observed for two of three residents (R1, R5) reviewed for abuse allegations in the sample of seven. The facility also failed to protect 2 residents (R1 and R5) with Dementia from abuse. These failures resulted in R1 and R5 having continued access to each other in the facility, resulting in R1 and R5 sexually assaulting each other on three different occasions. Findings include: The facility's Abuse Prohibition and Reporting policy dated 11-28-19 documents, "Purpose: To protect residents from any kind of abuse such as verbal, sexual, mental, and physical. Facility employee or agent who become aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If the matter involves alleged abuse or results in bodily injury, the Administrator shall provide the Illinois Department of Public Health with an initial notice of the alleged abuse as soon as possible, but more than two hours after the matter becomes known. The Administrator shall notify the resident's representative of the alleged abuse. The administration shall immediately contact local law enforcement authorities in the following situation: Sexual abuse of a resident by a staff member, another resident, or a visitor. If the incident involves alleged abuse and substantiated evidence indicates another resident of the facility is the perpetrator of the abuse, then the Administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated. If another resident is the suspected perpetrator of	S9999		

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the abuse, then the suspected resident shall be supervised 1:1 (one on one) or kept physically separate from all other residents until further orders."

The facility's Abuse Prohibition Policy dated 11-28-19 documents, "Purpose: To protect residents from any kind of abuse such as verbal, sexual, mental, physical, involuntary seclusion, neglect, misappropriation of property, exploitation, and any physical/chemical restraint. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Sexual coercion shall include any intentional or knowing touching or fondling of a non-consenting resident's sex organs, anus or breast either directly or through clothing for the purpose of sexual gratification or arousal of the accused."

R1's current Physician's Order Sheets (POS's) document R1 has diagnoses of unspecified behavioral and emotional disorders with onset occurring during childhood/adolescence, Alzheimer's Disease, and Major Depression.

R1's Minimum Data Set Assessment dated 9-8-20 documents R1 is severely cognitively impaired.

R5's current POS's document R5 has diagnoses of Dementia with behavioral disturbance and Major Depression.

R5's Minimum Data Set Assessment dated 8-11-20 documents R5 is moderately cognitively impaired and R5 walks independently inside and outside of her room.

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On 11-13-20 at 11:40 AM R5 stated, "I love that man. We are friends and he can play with my breasts." During this time R1 and R5 were lying in bed in their rooms. R1 and R5's rooms were next door to each other, and both R1 and R5 reside on the specialized Dementia care unit.

On 11-13-20 at 11:11 AM V11 (Dementia Unit Coordinator) stated, "On October 13, 2020 (R1) made sexual comments to (R5). (R1) was telling (R5) that he was going to rape (R5). I did not report this incident to (V1/Administrator)."

On 11-13-20 at 11:22 AM V12 (CNA/Certified Nursing Assistant) stated, "(R1) has grabbed (R5's) breasts twice. Last month (R1) was working with therapy and took off running away from the therapist. (R1) then went up to (R5) and squeezed (R5's) left breast. We (staff) wrote statements about this incident and gave them to (V23/Licensed Practical Nurse)."

On 11-14-20 at 7:10 PM V19 (CNA) stated, "A couple weeks ago (R1) and (R5) were in the dining room and (R5) was making moaning noises. (R5) was standing next to (R1), and (R1) was sitting in the chair. (R5) was rubbing (R1's) genitals on the outside of his pants and (R5) was moaning. I am not aware of any interventions we are to use to keep (R1) and (R5) separated. I did not report this incident to (V1). I am not sure if (V22) reported the incident to (V1)."

On 11-14-20 at 7:30 PM V20 (CNA) stated, "(R5) always tries to go in (R1's) room. A couple weeks ago (R1) and (R5) was in the dining room and (R1) was telling (R5) to go in his room so they could try to make a baby."

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On 11-14-20 at 7:35 PM V21 (CNA) stated, "Around two or three weeks ago (R5) and (R1) were in the dining room. (R5) was rubbing the outside of (R1's) pants in the genital area. (R1) was telling (R5) to rub faster. (V22/Registered Nurse/RN) was the nurse that witnessed this. I thought (V22) would notify (V1). I did not report this to (V1/Administrator)."

On 11-13-20 at 1:00 PM V1 (Administrator) stated, "It was not reported to me that (R1) told (R5) that he was going to rape (R1). I have not done an investigation. I was never informed that (R1) had grabbed (R5's) breast. If I would have known I would have investigated this as potential abuse."

On 11-15-20 at 8:40 AM V11 stated, "We (facility staff) have never met to discuss (R1) and (R5's) sexual encounters or developed care plan interventions to keep (R1) and (R5) safe from each other's sexual advances. We (facility staff) cannot do anything about (R1) and (R5's) sexual advances towards each other if we are not made aware of them. We have not done anything differently or developed any new interventions to keep (R1) and (R5) from making sexual advances since you (this surveyor) informed us of the allegations on Friday (11-13-20)."

On 11-15-20 at 9:00 AM V1 stated that he was not made aware of R5 rubbing R1's genitals on the outside of R1's pants, so an investigation has not been done."

On 11-15-20 at 2:35 PM, V22 (RN) stated, "I cannot recall the night that (R5) was rubbing (R1's) genitals above his pants. (V1) asked me about (R5) rubbing (R1's) penis above his pants last night and I told him I could not recall."

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On 11-15-20 at 10:40 AM V24 (R5's Family Member) stated, "(R5) would think that it was very offensive to have her breast grabbed or to be told she was going to be raped. (R5) would have called the police and family immediately. (R5) would be crying and would fear the person that did it, especially if they were living in the same area. (R5) would be devastated to know that sexual advances are being made between her and (R1). (R5) does not have her right mind and is demented. The facility should have kept (R1) and (R5) separated at all times."

On 11-15-20 at 10:55 AM V25 (R1's Family Member) stated, "No sexual advances would be being made if (R1) was in his right mind. I have been told that (R5) tries to kiss (R1) and tries to go in (R1's) room all of the time. When we (R1's Family) would visit before March 2020, (R5) would come up and try to kiss (R1) in front of us. The facility should keep (R1) and (R5) separated."

The facility's Abuse Investigations dated 10-1-20 to 11-12-20 do not include any abuse investigations or notifications to the state agency and police regarding R1 and R5's sexual abuse allegations. R1 and R5's medical records and the interdisciplinary notes do not include any documentation about the three different occasions of sexual abuse between R1 and R5.

R1's Behavioral Plan of Care dated 8-27-20 documents R1 has been making inappropriate sexual comments and sexual advances towards others. R1's current Plan of Care documents the following approaches: Before staff starts care on R1, staff will talk to R1 about fishing and how he caught big fish back in the day. Explain to R1

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that R1's comments are inappropriate and other people do not like to be talked to in this manner. Re-direct R1 from behaviors with conversation about his wife and daughter. Administer Quetiapine. Administer Melatonin at bedtime. Administer Sertraline once daily.

R1's Behavioral Care Plan dated 8-27-20 does not include any documentation or interventions to address R1 making inappropriate sexual comments, or sexual advances towards another resident (R5).

R5's current Plan of Care dated 11-29-19 documents that R5 has instances of verbal and physical behaviors towards others and makes sexual comments and unwanted sexual advances towards others. This same care plan has had no new behavioral interventions or updates since 9-1-20 and does not address R5's sexual advances towards another resident (R1).

(A)

Licensure finding 2 of 2:

300.610a)
300.1210 b)
300.1220 b)2)
300.1610a)1)
300.1620a)

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

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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 resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.1610 Medication Policies and Procedures

a) Development of Medication Policies
1. 1) Every facility shall adopt written policies

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and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

these requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure a physician ordered medication (blood thinner) was administered for one of three residents (R4) reviewed for medication errors in the sample of seven. This failure resulted in R4 exhibiting chest pain and anxiety resulting in R4 requiring hospitalization and treatment of bilateral pulmonary emboli (blood clots in both lungs).

Findings include:

The Facility's Pharmaceutical policy dated

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S9999	Continued From page 10 10/18/19, states "All orders received in the facility either by telephone or direct order shall be immediately transcribed onto medication administration record and physician's order sheet and may be done by using (Electronic Medical Records)." R4's Hospital Discharge records dated 8/3/20, document R4 was ordered Eliquis (blood thinner) 5 milligrams by mouth every 12 hours for a diagnosis of blood clots in bilateral lower extremities. R4's Physician Order Sheet and Facility Medication Administration Record dated 8/3/20 through 8/16/20, does not include the order for R4's Eliquis or document that R4 received any Eliquis during that time period. R4's Nurses Notes dated 8/16/20 at 6:39 p.m., document R4 complained of pain to her chest that she rated at 9 on a pain scale of 1-10. This same Nurses Note documents R4 was pale, visibly anxious, grabbing her chest and that R4 was sent to the local hospital for evaluation. R4's Hospital Records dated 8/16/20, document R4 was admitted to the hospital with a diagnosis of blood clots in both lungs. R4's hospital records indicate she was in the hospital from 8/16/20 to 8/19/20, due to not receiving the Eliquis and required anticoagulant therapy (blood thinner) for the blood clots in both of her lungs. R4's Hospital History and Physical, documented by V33 (R3's Hospital Physician), dated 8/17/20 at 12:13 a.m., states "(R4) is supposed to be on Eliquis although it appears she has not been on Eliquis at (the facility). (R4) was evaluated in the (Emergency Room) tonight and found to have	S9999		

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S9999	Continued From page 11 bilateral pulmonary emboli." V33 also documented under the Assessment and Plan to "Restart Eliquis as (R4) doesn't appear to be on any blood thinners." On 11/16/20 at 9:51 a.m., V1 (Administrator) stated R4 did not receive her Eliquis as ordered by the physician from 8/3/20 through 8/16/20 and required hospitalization for treatment of bilateral pulmonary emboli. On 11/18/20 at 9:30 a.m., V1 stated, "Yes, I totally agree that we failed (R4) and she did not get her Eliquis and ended up with blood clots." (A)	S9999		