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NEW ATHENS HOME FOR THE AGED	203 SOUTH JOHNSON STREET NEW ATHENS, IL 62264

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S 000	Initial Comments Facility Reported Investigation (FRI) to Incident of 12/16/20/IL129696: F600, F607, F609 anf F610 A partial extended survey was conducted: F868, F943 and F947.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)2) 300.3240a)b) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) THE REQUIREMENTS WERE NOT MET	S9999		

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S9999	Continued From page 2 EVIDENCED BY: Based on observation, interview, and record review, the Facility failed to prevent sexual abuse for one of three residents (R2) reviewed for abuse in the sample of 11. Also, the facility failed to immediately report allegations of abuse to the administrator. This failure has the potential to affect all 40 residents living in the facility. Finding includes: V19, Certified Nurse's Assistant (CNA) witnessed V20, Registered Nurse (RN) perform oral sex on R2. V19 left the facility without immediately reporting this incident to the Administrator. Due to the facility's failure to timely report this allegation of abuse, this allowed V20 to continue to work an entire shift, having continued access to R2 and all residents in the facility. This failure increased the likelihood of continued abuse of R2 and all residents in the facility due to their vulnerabilities including but not limited to cognitive and/or physical impairments R2's Physician Order Sheets for December 2020, documents R2 has diagnoses of muscle weakness, personal history of traumatic brain injury and anxiety. R2's Minimum Data Set (MDS) dated 9/30/2020 documents R2 has moderately impaired cognition for decision making. The MDS also documents R2 does not walk, uses a wheelchair, and requires staff assistance for toileting, bed mobility, and transfers.	S9999		

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R2's Care Plan, date initiated of 2/7/2020, documents R2 is at risk for abuse and neglect due to cognitive impairment, physical limitations, difficulty in communication, and heavy care needs.

A report completed by V1, Administrator, dated 12/23/2020 documents, "This is a report regarding an incident that the (V2, Director of Nurses/DON) and I were made aware of December 22, 2020 at 3:00 PM. (V19, Certified Nurse's Aide/CNA) approached the DON and reported that he had observed the overnight nurse (V20) performing oral sex on resident (R2) on 12/16/2020 at approximately 10:23 PM." The Report documented "An interview was completed with (R2) on 12/23 at 10:00 AM and he did confirm that (V20) had indeed performed oral sex on him without his consent. A phone call was made to (V20) and a message was left to contact the Facility. (V20) did call at approximately 10:45 AM and he was directly asked if he had performed oral sex on (R2). (V20) responded by stating that he had but 'it is not what you think,' (V20) then went on to state that (R2) had told (V20) that if he did not 's*** his d***' he would tell the administrator that (V20) was having sex with him." The Report documented "The POA (Power Of Attorney) then reported that over the past several months her brother, (R2), made statements to the effect, that 'a nurse was going to s*** my d***' but sister felt it was not significant as (R2) has a history of traumatic brain injury and will frequently make inappropriate statements. She called administrator roughly 20 minutes later to report her brother had made similar comments to her other sister who also dismissed them as (R2) being (R2)."

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S9999	Continued From page 4 On 12/16/2020, V1, Administrator began conducting one-on-one conversation with R2 to build a relationship to monitor R2's state of mind, and coping skills. Administrator began to monitor the frequency of calls R2 made to his family to monitor R2's current coping skills. On 12/23/2020 at 5:35 PM, V1, Administrator stated "One of my CNA's (V19) on 12/16/2020 witnessed (V20) giving (R2) a b*** j**. He just told me about this on 12/22/2020. He did not report it to us after it had happened. (V19) stated he left the facility and then realized he forgot his hat so he went back in and went into (R2's) room and the curtain was pulled and he pulled the curtain back and saw (V20) performing oral sex on (R2). (V19) then left the building and did not report it to anyone until yesterday (6 days later). The next day after the incident, (V20) quit but he told me he was quitting because of the schedule. I didn't think anything of it until later when I found out he had been caught. I called him later (V20) and he admitted doing it but said it was not what I think, (V20) stated that (R2) had told him that if he didn't 's*** his d***' he would tell the administration that (V20) was having sex with him. I contacted the Ombudsman and I don't remember who I spoke with and then I called the police. When I contacted the Power Of Attorney she was initially shocked but did tell me that for the past several months her brother (who had history of traumatic brain injury) would frequently tell her over the last several months that a 'nurse was going to s***his di**' but his sister felt it was not significant because he has made inappropriate statements before. She called me back about 20 minutes later and stated her other sister who also dismissed the comments said (R2) was telling her those same comments as	S9999		

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well. I do not know why he did not report it immediately or why he walked out of the building without making sure (R2) was safe and he left him alone with (V20) all night. It makes me shudder."

On 12/23/2020 at 7:35 PM, R2 stated, "(V20) the nurse s***** my d***. I didn't want him to do it but there was not much I could do about it being in this place and all. I don't know why he did that. He kept telling me he was going to do that. I am not sure how long and then he did it. I did not give my consent. I feel safe now because (V20) is not here anymore. I did not ask him to do that and I did not tell him it was okay to do that to me. I don't want to get anyone here in trouble. I don't know why he did that I don't like men. I like women."

On 12/29/2020 at 5:09 PM, V18, CNA stated," On 12/22/2020 (V19) came to me and said "Hey, I want to tell you why (V20) got fired. I asked what happened and he pulled me in the bathroom and told me he caught (V20) s****** (R2's) d***. (V19) had told me it had happened a few days ago but he did not report it." V18 stated "(V19) was all scared and I told him to go and find (V2) and we went searching for her and when we found the Director of Nursing (DON) we told her everything that had happened. We then went to the Assistant Director of Nursing's office and told everybody inside there what had happened including (V1). We have not had any training for a while except for right after his happened. I am not sure when we were last trained on what we are supposed to do for something like this but I know we are supposed to report it and I told (V19) if he didn't report it he could get into big trouble and I made sure he reported it and we went together to (V2)."

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On 12/29/2020 at 5:18 PM, V19, CNA, stated, "On 12/16/2020 I left the Facility and went outside then I realized I had left my hat. I went back into the (Facility) and I went down the hall and I heard something and (R2's) curtain was pulled so I lifted the curtain and saw (V20) s****** (R2's) d***. I was in shock. I could not believe what I was seeing. I just left and did not tell anyone that day. I could not concentrate and kept seeing it over and over again in my head. I told people I thought I could trust what happened later on when I was working. I told (V18), (V10, CNA), (V14, CNA) what I saw and (V18) told me I needed to report it. I reported it later on, not when it first happened. I reported it with (V18) to (V2, Director of Nursing), a few days later, I guess. No, I was not trained in how to respond to something like this."

On 12/30/2020 at 2:43 PM, V28, stated, "We (my sister and me) asked (R2) if he was okay with (V20) touching him down there and he said " no" , he did not want him to touch him because he likes girls not guys. Initially, when (V1) told me (R2) had been sexually assaulted I never dreamed in a million years that it was a guy nurse. After (V1) told me what happened I got to thinking (R2) had been talking about a male nurse named (V20) who he kept telling us, he kept telling him he was going to s*** his d*** but we just did not put two, and two together. (R2) was traumatized with this happening to him especially since it was a man. (R2) is getting really upset now because everyone is asking him questions and he is starting to feel that maybe he did something wrong and did not want to get anyone in trouble. (R2) is such a kind man it upsets us to the core. We had (R2) in a different facility before and every day he would call us 40 plus times a day. When we moved him to the

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(Facility) he was becoming well-adjusted and settling in and we were only getting one phone call a day until this happened and now, he is calling us nonstop now, and upset about everything that happened."

On 12/30/2020 at 3:36 PM, V17, Physician stated "I would not expect any staff member to perform oral sex on any residents and it was my understanding (R2) did not consent and it is against all ethics for any staff member to behave in such a way."

On 12/31/2020 at 10:03 AM, V2, Director of Nursing (DON) stated, "It was Tuesday (12/22/2020) and I was working the floor when (V19) came behind me and (V18) and they said they needed to talk to me and we went inside of the Medication Room and (V19) was acting distraught and I thought maybe someone from his family had died and then he said 'I know why (V20) quit.' V2 stated that V18 stated he worked the night on 12/16/20. V2 stated V18 told her he clocked out and left the building but then realized he had forgotten his hat. V2 stated V18 told her when he back inside he saw R2's room curtain was pulled and pulled the curtain back and saw V20 bent over giving R2 h***. V2 stated " I never asked him why he did not report it immediately. I could see he was very upset. After he told me this, I told him we had to go to the police." V2 stated "(V18) was there too when (V19) told me and she told me that she had asked (R2) if that had really happened and admitted to her that it had happened, and it was without his consent. (V19) told me he had told other staff members, but I don't know who he told staff wise except for (V18). When he told the other staff members I don't know when he told them and I did not ask

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him why he waited so long to report it, but I could tell he was really upset about it. I know we should have protected our residents and we are all freaked out that it happened to (R2) and feel awful. I am new to the position of DON. I am not sure we even have a protocol for this this. If there is a protocol, I do not know what steps we did or did not take. I immediately had (V19) and (V18) tell (V1) everything and the ADON was there as well. We contacted the police." V2 stated "If any staff member suspects abuse, they are supposed to report it immediately to (V1)."

On 12/31/2020 at 11:39 AM, V27stated "No I did not document who those residents were or what they actually said, and I did not follow up with any questions. I am not sure what the Abuse Pathway even is. I do not have anything documented about it. I think maybe it could have been (R10) but I am just not sure."

On 12/31/2020 at 11:41 AM, V1 stated "I am new to this position, but I would expect any and all staff to report to me immediately if they suspected or witnessed any resident being abused."

On 12/31/2020, at 11:43 PM, V3, Assistant Director of Nursing (ADON) stated any allegations of abuse should be reported immediately to the Administrator

On 12/31/2020, the Facility's Abuse Investigations were reviewed. There was no investigation conducted regarding allegations made during 11/3/2020 Resident Council Meeting.

Resident Council Interview Sheet completed by V27, Activity Director dated November 3, 2020 document the following question: "Have staff

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S9999	Continued From page 9 made you feel afraid, humiliated, or degraded?" The Interview documented "Yes" as a response to this question. The Interview sheet documented "If concerns are identified, refer to the Abuse Pathway." The Interview Sheet documented 2 residents had issues with this question; however, there were no names identified on this sheet. The Facility's Resident Census and Conditions of Residents form, CMS 672, dated 12/23/2020 documented the facility had a census of 40 residents. On 1/2/21 the facility provided an abuse policy to the surveyors. The Facility's undated Abuse and Neglect Policy documents, "It is every one's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately. Individuals making reports should do so in confidence to protect resident's dignity, right to confidentiality, and freedom from staff retaliation." The Policy provided to the surveyors did not address how the facility would conduct a thorough investigation of all allegations of abuse. This policy documented the Administrator would serve as the Abuse Prevention Coordinator. " A "	S9999		