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 |
|---|---|---|---|
| | IL6003081 | A. BUILDING: ________ B. WING ________ | C 10/05/2021 |

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| DECATUR REHAB & HEALTH CARE CT | 136 SOUTH DIPPER LANE DECATUR, IL 62522 |

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| S 000 | Initial Comments<br><br>Facility Reported Incident of September 5, 2021/IL138247<br><br>An extended survey was conducted. | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)3)<br>300.3240f)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

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 requirements were not met as evidenced by:

Based on interview and record review, the facility failed to supervise residents (R1 and R2) with a known history of inappropriate sexual behavior to prevent resident to resident sexual abuse. This failure resulted in R2 being sexually abused by R1. Staff allowed R1 and R2 to go unsupervised with unrestricted access to each other resulting in

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sexual behaviors between two residents who are unable to consent, exposing them to abuse. This failure affects two (R1, R2) of residents reviewed for abuse in the sample list of 12 residents.

This failure resulted in an Immediate Jeopardy.

While the immediacy was removed on 10/5/21 at 10:25am, onsite observation, interview and record review verified the facility is in the process of training staff, including re-education on the facility abuse policy and monitoring R1 and R2. The facility remains out of compliance at a severity level two.

Findings include:

R1's Physician's Notes dated 4/9/21, documents R1's diagnoses including Cerebrovascular Accident (CVA), Dementia and memory loss. This note documents R1 had been hospitalized and was evaluated while in the hospital and "felt to be incompetent." R1's Brief Interview for Mental Status dated 7/19/21 documents R1 is severely cognitively impaired.

R2's Care Plans dated 1/14/2013, document R2 has a diagnosis of Pick's Dementia and requires supervision and cues to complete activities of daily living and wanders around the facility. These Care Plans also document R2 has a history of inappropriate display of sexual behavior related to R2's diagnosis of Picks Dementia.

9/5/21 11:15 am, R1's Progress Notes document R1 was found next to R2 in a recliner. This note documents V3, Licensed Practical Nurse (LPN) observed R1 "attempting to put (R1's) hands on (R2) inappropriately". V3 intervened and separated R1 and R2. V3 notified V16 Regional

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Director (RD). This note documents "will continue to monitor (R1) and keep separate from females."

The facility's interview dated 9/9/21 with V3, documents "resident incident" and that V3 overheard another staff (unidentified) saying R1 had sat in recliner with R2. When V3 investigated, (V3) saw R1 trying to place R1's hands inside R2's pants, grabbing R2's waistband and trying to put (R1's) fingers in.

9/5/21 11:49am, fax notification sheet to V7 (Physician) documents "Another resident (R1) attempted to sexually inappropriate touch (R2).", there was no further interventions documented.

R1's Progress Notes dated 9/5/21 7:40pm document, on 9/5/21 at 5:30pm, V4 (Registered Nurse - RN) responded to a call light that was sounding. V4 and V5 (Certified Nursing Assistant - CNA) walked into the room and observed R2 laying on R2's back on a bed with R2's pants down. This note documents R2's feet were in front of R2's vaginal area. R2 "was laying the wrong way", positioned across the bed with R2's head toward the wall. R1 had R1's pants down and turned around when V4 and V5 entered the room. R1 saw V4 and V5 and pulled up R1's pants and started to exit the room. V5 "escorted" R1 out of the room. V4 assisted R2 to get R2's pants pulled up and "walked (R2) out of the room." This note also documents both R1 and R2 have Dementia and wander throughout the facility. R2 is unable to communicate. "(R2) didn't look like anything had occurred because there were no sign of body fluids, etc."

R1's Hospital Emergency Room physician notes dated 9/5/21, document R1 is oriented to person only, ambulates to the bathroom and is up in the

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room without difficulty. This note documents R1 was found standing in a female resident's (unidentified) room with no clothes on.

On 9/21/21 at 2:15pm, V4 Registered Nurse (RN) stated V4 was the nurse on duty on 9/5/21 and was one of the staff members to answer the call light and observe the inappropriate sexual behavior. V4 stated V4 felt R1 "knew what (R1) was doing" because as soon as V4 and V5 answered the call light and found R1 and R2 with their pants down in the room, R1 immediately pulled R1's brief and pants up and began to leave the room. V4 stated R1 was fixated on R2 for a couple of days following the incident. V4 stated V4 found R1 holding R2's hand in the dining room as V4 documented on 9/7/21. This was two days after R1 and R2 were found in the room with no clothing on from the waist down. V4 stated R1 and R2 were behind V4 when V4 turned around and witnessed the hand holding. V4 stated R2 could not have removed/taken R2's pants down by R2's self. V4 stated R2 had the call light in one of R2's hands but could not recall which hand, which "was odd" because R2 doesn't know how to use the call light. V4 stated when V4 came in to work that day (9/5/21) around 2:00pm, during report with the nurse (V4 could not remember who the nurse was) it was mentioned "something" had happened and "everyone" was notified that needed to be. V4 could not remember what V4 was told that had happened.

Regarding the 9/5/21 5:30 pm incident, V4 stated R2's feet were propped up on the bed with knees bent upward and R1 was standing right in front of R2. V4 stated V4 spoke with the local police department to report the sexual abuse incident. V4 stated R1 and R2 were at the bed that is closest to the door of the room with R2 laying on

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| S9999 | Continued From page 5<br><br>R2's back. R2's body was across the bed against the wall with head by wall. R1 and R2 both had their pants and briefs down, exposing themselves to each other. V4 stated V4 assisted R2 to pull R2's brief and pants up. V4 stated V5 escorted R1 out of the room. V4 was unsure of when R1 and R2 were last observed together. V4 did not know where R1 was taken when V5 escorted R1 out of the room. V4 stated "staff" mentioned when R2 was first admitted to the facility, that R2 had promiscuous behaviors and residents would take advantage of that. V4 stated that on 9/6/21 R1 kept "circling" R2 and was fixated on R2.<br><br>On 9/23/21 at 10:10am, V12 (Housekeeper) stated V12 observed R1 "dipping (R2's) hand in (R1's) pants." V12 stated R1 kept trying to put R1's hands in/down the front of R2's pants multiple times. V12 stated R1's hand was "down (R2's pants) enough to R1's knuckles" and was trying to push down further in to R2's pants. V12 stated V12 had not been contacted by V1 (Administrator in Training - AIT) for an interview regarding the incident on 9/5/21. V12 stated R1 was purposefully touching R2 in a "sexually inappropriate way" and R2 would not be able to consent or know what was happening.<br><br>On 9/23/21 at 12:05pm, V15 (Cook) stated V15 came out of kitchen on 9/5/21 (unsure of what time) and saw R1 sitting next to R2 with R1's arm around R2 and "leaning in to (R2)." V15 stated V15 told staff standing there, "you know how (R1) is and you better get (R1), that is not right." V15 stated R1 and R2 are not cognitively aware to make those decisions. V15 stated some staff "thought it was cute". V15 stated when V3 (LPN) responded, R1 was trying to put R1's hands down R2's pants. V15 stated V15 was not contacted for a witness interview related to R1 and R2's sexual | S9999 | | |

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inappropriateness on 9/5/21 at 11:15am.

R1's Pharmacy Consultation Report dated 9/10/21, documents R1 "has experienced an increase in unusual behavior patterns" (resident to resident sexual behaviors and inappropriate remarks).

An Immediate Jeopardy situation was identified on 09/27/21 at 3:33pm.

The Immediate Jeopardy was identified to have begun on 9/5/21 at 11:15am, when R1 was observed touching R2 in a sexually inappropriate way. R1 and R2 were not kept separated/supervised. On 9/5/21 at 5:30pm, R1 and R2 were found in the room of other residents, both with pants down, exposing their lower bodies, perineal areas to one another. R2 was on the bed laying across the bed with buttocks toward the outer edge of the bed and head to the wall with R1 standing in front of R2.

On 09/27/21 at 3:33pm, V16 Regional Director (RD) was notified of the Immediate Jeopardy situation.

The surveyor confirmed through observation, interview and record review that the facility took the following actions to remove the immediate jeopardy:

1.) On 9/27/21, V16 Regional Director (RD) in-serviced V1 Administrator in Training (AIT) on the Abuse Prohibition Policy and the importance of completing a thorough investigation on all allegations/incidents. V1 also received education regarding the importance of ensuring 1:1 supervision and 15-minute visual checks are carried out and documented.

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| S9999 | Continued From page 7<br><br>2.) On 10/5/21 at 10:25am, V1 provided documentation that additional in-servicing on the facility's Abuse policy was initiated on 10/5/21. The facility will complete random weekly in-services on the facility Abuse policy and the importance of ensuring residents receive 1:1 supervision or 15-minute checks that require are required. There is no documentation of this being completed after 9/25/21 as of 10/4/21.<br><br>3.) Social Services (SS) and Activities departments have increased their sessions with R1 and R2, working with R1 and R2 separately. Per V1, V24 (Social Services) stated V24 was unable to complete the number of sessions (3 sessions weekly) as documented in the facility's abatement plan. There is no documentation that V9 (Activities Director) has increased R1 or R2's activity sessions since 9/27/21. The facility is working with V9 as to where those sessions can be documented.<br><br>4.) On 10/4/21 at 11:00am, V1 provided updated documentation that the Interdisciplinary Team (IDT) reviewed residents involved in resident-to-resident abuse allegations to ensure resident specific targeted behaviors have appropriate person-centered interventions.<br><br>5.) On 9/27/21 the IDT was in-serviced by V16 (Regional Director) to review residents for changes in behaviors to investigate and identify any potential triggers prior to an incident. The in-service included to ensure that resident centered interventions are developed to alleviate/decrease behaviors and to communicate identified triggers and interventions to staff (Completion date of 9/27/21). | S9999 | | |

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| S9999 | Continued From page 8<br><br>6.) Residents identified during IDT review for behavioral changes in #5 will be discussed during morning meeting and a root cause analysis will be completed to determine potential triggers.<br><br>7.) New interventions will be communicated to staff using a communication book. As of 10/4/21 at 2:10pm, V4 Registered Nurse (RN) was unaware of the "communication book" and did not know what staff or V4 was supposed to do with the book or what it was for. V1 (Administrator in Training) stated V1 is "updating (direct care staff) when (V1) sees them" related to the communication book.<br><br>(B) | S9999 | | |