Illinois Department of Public Health

CTATEMENT OF DESIGNACIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED C 03/09/2021	
		IL6005607				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LUTHER	AN HOME FOR THE A	M(4 =1)	OAKTON S			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE	
S 000	S 000 Initial Comments		S 000			
	Facility Reported In / IL131513	vestigation (FRI) to Incident of				
\$9999	99 Final Observations		S9999			
	Statement of Licensure Violations:					
	300.610a) 300.1210b) 300.3240a)					
	Section 300.610 Re	esident Care Policies				
To the Addition of the State of	procedures governing facility. The written be formulated by a land Committee consisting administrator, the administrator, the admedical advisory coof nursing and other policies shall comply The written policies the facility and shall	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed				SI
	Section 300.1210 G Nursing and Person	General Requirements for all Care				
1 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	and services to attain practicable physical,	rovide the necessary care n or maintain the highest mental, and psychological ident, in accordance with		Attachment A Statement of Licensure Violations		
linois Depart	ment of Public Health					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 05/04/2021 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C IL6005607 8. WING 03/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 WEST OAKTON STREET** LUTHERAN HOME FOR THE AGED **ARLINGTON HTS, IL 60004** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 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 300.3240 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) These requirements were not met evidenceed by: Based on interview, and record review, the facility failed to ensure a resident was free from sexual abuse which resulted in a staff member making sexually inappropriate comments to a resident (R1) for 1 of 3 residents reviewed for abuse in the sample of 4. The findings include: A facility incident report dated February 26, 2021 showed, "A culinary employee reported that he overheard a CNA (Certified Nursing Assistant) say to (R1), "If you wash your hands, you can touch my chingadara." In this situation. "chingadara" was a slang word which referenced male genitalia." The report showed the referenced CNA (V7) was interviewed and admitted to telling R1, "If you follow me then you can touch me." The report showed the allegation of sexual abuse was substantiated involving R1 and V7 CNA. Illinois Department of Public Health

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6005607 03/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 WEST OAKTON STREET** LUTHERAN HOME FOR THE AGED **ARLINGTON HTS, IL 60004** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 R1's Care Plan dated October 11, 2020 showed R1 was severely cognitively impaired due to his diagnosis of dementia. On March 8, 2021 at 11:05 AM, two attempts were made to interview R1 in regards to the February 26, 2021 incident. The attempts to interview R1 were unsuccessful as R1's verbal response to questions was babbling, and incoherent speech. On March 8, 2021 at 11:45 AM, V7 CNA stated on February 26, 2021, "I was trying to get (R1) to wash his hands. (R1) can have behaviors and refuse to do things. We were out in the main dining room by the sink. He kept trying to touch my penis and offer me oral sex. I ignored him. I know it was wrong but I then told him that if he washed his hands, I would let him touch my "chingadara". Chingadara is Spanish for penis or male parts." On March 8, 2021 at 12:52 PM, V11 Dietary Aide stated, "On that morning (2/26/21), I was cleaning up dishes in the dining room on the dementia unit. (V7 CNA) was at the sink in the dining room with (R1). I overhead (V7 CNA) tell (R1), "I know you want to touch my chingadara. Wash your hands and I will give you the banana." On March 8, 2021 at 11:30 AM, V10 CNA stated on February 26, 2021, he overheard V7 CNA tell R1, "Come and wash your hands before you touch me or my chingadara." On March 8, 2021 at 9:50 AM, V3 Assistant

Illinois Department of Public Health

Director of Nursing (ADON) stated on February 26, 2021, V7 CNA told her, "One of the culinary people overheard me tell (R1) that if he washed

his hands, I would let (R1) touch me."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING IL6005607 03/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 WEST OAKTON STREET LUTHERAN HOME FOR THE AGED ARLINGTON HTS, IL 60004** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) S9999 Continued From page 3 S9999 The facility's Abuse and Neglect of Resident policy dated November 26, 2019 showed, "The resident has the right to be free from abuse. neglect, misappropriation of resident property, and exploitation ... Sexual abuse is nonconsensual sexual contact of any type with a resident, including, but not limited to, assault. rape, or sexual harassment ." " B " Illinois Department of Public Health