STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 01/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 61455

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S 000	Initial Comments Complaint Investigation #2140475/IL130397	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 300.610a) 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. 300.1210b) 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. 300.3240a) An owner, licensee, administrator, employee or	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

agent of a facility shall not abuse or neglect a resident.
(Section 2-107 of the Act)

These regulations were not met as evidenced by:

Based on record review and interview the facility failed to protect a resident (R1) from sexual abuse by a staff member (V3/Licensed Practical Nurse) and failed to provide adequate supervision of a cognitively impaired resident (R4) to prevent abuse for two of four residents (R1, R4) reviewed for abuse in the sample of eight. These failures resulted in (R1) feeling uncomfortable and becoming severely depressed, which triggered (R1) to have a mental breakdown that required counseling and treatment.

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Findings include:

The facility's Abuse Prevention Program policy dated 11-28-16 documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Sexual Abuse is non-consensual sexual contact of any type with a resident. This facility is committed to protecting our residents from abuse by anyone including facility staff, other residents, consultants, volunteers, and staff form other agencies providing services to the individual."

R1's Pre-Admission Inpatient Psychiatry History and Physical Note dated 1-14-20 documents, "(R1) has a history of Huntington's Disease (diagnosed one year ago) and no previous

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psychiatric hospitalizations. (R1) was brought to the hospital due to worsening depression, hopelessness, and difficulties sleeping and functioning in his ADL's (Activities of Daily Living). (R1) reported having increased depression and suicidal ideation due to being diagnoses with Huntington's Disease. (R1) admitted to hospital for safety and stabilization."

R1's Minimum Data Set (MDS) Assessment dated 2-3-20 documents R1 is a 32-year-old who is cognitively intact and has diagnoses of Huntington's Disease, Anxiety, Depression, and Alcohol Dependence. This same MDS documents R1 was admitted to the facility on 1-21-20.

R1's Mood Assessment dated 1-21-20 documents R1 was moderately depressed. R1's Mood Assessment dated 3-20-20 documents R1's depression increased from R1 being moderately depressed on 1-21-20 to R1 being severely depressed on 3-20-20.

V3's Personnel Record documents V3 signed an acknowledgement of receiving training on the facility's Abuse Prevention Program upon hire (1-20-20).

R1's Investigation Notes dated 3-17-20 and signed by V11 (Previous Director of Nursing) document, "(R1) states that multiple times the previous night (3-16-20), (V3) came to (R1's) room and engaged in inappropriate personal conversations. During one conversation (V3) stated that she had brought her dog to the facility and had to wait for management to leave so that she could bring her dog inside the building. During another conversation at some point (V3) stated she had purchased some underwear

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online and that she needed (R1's) opinion regarding them later. Later (V3) brought the dog in and laid down on (R1's) bed and continued the conversation in which she spoke of her personal relationships with others and being hurt by everyone in her life. During the end of the conversation, (V3) pulled down her scrub bottoms, exposed her underwear, and asked (R1's) opinion about them. (R1) stated the conversations made him very uncomfortable and he does not trust (V3) with his care any further."

The facility's Reportable dated 4-1-20 to IDFPR (Illinois Department of Financial and Professional Regulation) documents, "Your complaint is against: (V3/Licensed Practical Nurse/LPN). Description of complaint: (V3) is seen and heard on a video in (this facility) talking to (R1) in a sexual manner. (V3) appears to be inebriated in the video. At the very end of the video the nurse can be heard talking about underwear she has ordered and then is seen pulling down her pants and exposing her buttocks to (R1). (R1) is a resident at the facility. This is not the first time this nurse has had questionable moral turpitude." R1's Medical Record from admission 1-21-20 through discharge 4-11-20 does not include any documentation in R1's Social Service Notes, Progress Notes, or Care Plan of R1 consenting to V3's Sexual/Personal advances towards him (R1).

On 1-25-21 at 9:40 AM V5 (Social Service Director) stated, "I saw a video that (R1) showed me back in March 2020. V3 (LPN) was in (R1's) room and pulled her pants down to show (R1) her underwear. (R1) stated he videoed (V3) because (V3) always would go in his room and make (R1) feel uncomfortable. (R1) was not ok with what (V3) was doing and definitely was not

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consensual. (R1) recorded (V3) to show us what (V3) was doing."

On 1-25-21 at 10:45 AM V4 (R1's Family Member) stated, "I saw a video from March 2020 that (R1) had taken. (R1) told me that (V3) was inappropriate with him on several occasions. (V3) would talk to (R1) about her personal problems and would tell (R1) that she would do anything for him. In the video (V3) was walking around seductively and dropped her pants, showing her underwear to (R1). (V3) asked (R1) what he thought of her a**. (R1) was very upset by it. (R1) was upset that a nurse was doing this to him and did not trust her. (R1) has Huntington's Disease and was confused by what (V3) was doing. (R1) has been very traumatized since this and had been receiving counseling. (V3) made (R1) feel very uncomfortable."

On 1-25-21 at 10:30 AM V3 (LPN) stated, "I would talk to (R1) about my family thinking I am a b***h. I felt like (R1) and I were dating two weeks after (R1) got to the facility. I would talk to (R1) about my personal issues all the time. I did pull down my pants and show (R1) my underwear and I asked (R1) if I had a nice a**. I knew I should not have had a sexual relationship with (R1) while he was a resident at the facility. I do not know what I was thinking. I sent (R1) a picture of my breasts without any clothing on and several pictures of my butt with underwear on. I know what I was doing was wrong. The facility fired me because of what I did with (R1). Professional regulations sent me a letter that I need one hour of continuing education training on sexual harassment. I have not had sexual harassment training yet."

On 1-25-21 at 11:10 AM R1 stated, "(V3) would

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come into my room and talk about her personal issues and home-life a lot. (V3) would have alcohol on her breathe. On 3-13-20 around 3:00 PM (V3) sat on the end of my bed and said she had something to show me later. I left my phone on record because I felt uncomfortable with how (V3) was talking to me. Later on (V3) pulled her pants down and showed me her underwear and told me that I should leave my girlfriend for her. (V3) would tell me that I could go home with her and live instead of living at the nursing home. The situation kept getting weirder. (V3) had sent me a picture of her breasts without clothing on. (V3) would message my wife and tell my wife that I wanted (V3). (V3) brought liquor into my room once and drank it. My whole room wreaked of alcohol. (V3) knew I was a recovering alcoholic. I have Huntington's Disease and it is hard for me to cope with what (V3) has done to me. It triggered me and scared me. I have had to have counseling and treatment because of (V3). I had a mental breakdown. (V3) was obsessed with me and kept wanting me to live with her. I was not comfortable with (V3's) advances towards me. I think (V3) was obsessed with me because I was the only young resident at the facility and (V3) always seemed to be drunk."

On 1-26-21 at 9:40 AM V11 (Previous Director of Nursing) stated, "I terminated (V3) on 3-19-20 for inappropriate behavior and sexual abuse of (R1). (R1) recorded (V3) being inappropriate with him to prove to us what (V3) was doing to him. (R1) was alert and orientated at the time of the report. (R1) even told me that he had increased anxiety from (V3's) sexual advances towards him. (R1) said that (V3) made him uncomfortable living in the facility that was supposed to be giving him help. We (facility staff) suspected that (V3) had worked while under the influence of alcohol."

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S9999	Continued From page 6 2. The Facility's Abuse Prevention Program dated 11/28/2016, states "Resident Assessment. As part of a resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis." R4's Physician Order Sheet dated 1/2021, documents R4 has diagnoses which include Dementia, Schizophrenia, Bipolar Disorder, Post Traumatic Stress Disorder, and Anxiety. R4's Minimum Data Set (MDS) assessment dated 1/1/21, documents R4 has moderately impaired cognition; ambulates with minimal assistance; exhibits behaviors that significantly intrude on privacy or activity of others; significantly disrupts care or living environment; and wanders. R4's most recent Care Plan, does not include any documentation about R4's wandering into other residents' rooms, putting him at risk for abuse, or any interventions to help prevent R4 from wandering into other residents' rooms. R2's MDS assessment dated 10/16/20, documents R2 is cognitively intact. R4's Incident Report dated 1/24/21 at 7:30 a.m., documents R4 wandered into R2's room and R2 kicked R4. R4 did not sustain any injuries.	S9999		

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S9999	Continued From page 7 On 1/25/21 at 11:07 a.m., R2 stated R4 wandered into his room a total of four times the morning of 1/24/21. R2 stated "I asked him (R4) nicely the first three times, not to come back into my room. The fourth time he came straight to my closet. I escorted him from my closet to the hallway. I kicked him in the butt. I know it was wrong but I warned him after three times of coming in my room." On 1/26/21 at 10:33 a.m., V2 (Director of Nursing) states R4 does frequently wander into other residents' rooms and tends to take their belongings or food. V2 stated R4's wandering and intruding on other residents privacy has worsened (as noted on R4's MDS assessment dated 1/1/21). V2 stated R4's most recent Care Plan does not address R4's wandering, intruding on other resident's privacy, or the fact that R4 is at increased risk for abuse due to his wandering. V2 stated "I am aware that we need to work on (R4's) care plan and interventions regarding his wandering into others rooms. (R4) is at increased risk for abuse due to his wandering. Staff have to keep a close eye on him when he's awake." On 1/25/21 at 10:30 a.m., V1 (Administrator) stated on 1/24/20 R2 admitted to kicking R4 "in the butt" because R4 had come into R2's room four times that morning. V1 stated the physical abuse was not witnessed by staff. V1 stated R4 is at high risk for abuse due to impaired cognition and wandering into other residents' rooms. (B)	S9999		