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S 000	Initial Comments Complaint Investigation 2181257/IL131267	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1220 b)2) 300.1220 b)3) 300.3240 f) 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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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.	S9999		

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S9999	Continued From page 2 These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was free of unwanted sexual touch from another resident (R2), failed to ensure R2 did not have further contact with R1, and failed to assess a resident (R1) and intervene with the appropriate person-centered and individualized psychosocial services to meet the needs of the resident who was sexually assaulted. This affected one resident (R1), of two residents, reviewed for abuse, and it resulted in R1 having nightmares and sleep disturbances since the day of the incident that were not identified or addressed by staff. Findings include: R1's MDS (Minimum Data Set), dated 12/6/20, shows a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact). R2's MDS, dated 12/17/20, shows a BIMS score of 15 (cognitively intact). R1's face sheet shows that R1's diagnoses include, but are not limited to, Major Depressive Disorder and Hypertension. R2's face sheet show that R2's diagnoses include, but are not limited to, Major Depressive Disorder, Hypertension, and Alcohol Abuse with Alcohol-Induced Anxiety Disorder, Insomnia and Schizophrenia. On 3/3/21 at 11:05 AM, during this investigation, R1 stated, "He got naked and came and grabbed my pants, touched my penis, tried to pull down my pants. I pushed him away and yelled for help." R1 was asked if the incident affected him in any way; R1 stated, "Since then, I could not sleep at night. I was having nightmares about what	S9999		

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happened to me. He was moved to another room just across the hall, and when I meet him in the hallway, I get scared that he could do it again. I am 61 years old; I don't smoke, I don't drink. (V10, staff from an outside agency) said that they are working on a new place for me and I should be out of here by next Wednesday."

On 3/3/21 at 11:20 AM, R2 was interviewed. R2 stated, "I had a couple of drinks right after dinner, and they said I was acting up." Inquired from R2 where he got the alcoholic drink from, but R2 was reluctant to respond.

An attached email, dated 2/23/21 at 5:38 PM, received from an outside agency, states "(R2) came back to the nursing home intoxicated. (R2) took his clothes off and was touching himself. He then started touching (R1) inappropriately. The Home moved (R2) one room over so (R1) is still seeing (R2) daily."

During the initial tour on the third floor, it was observed that R2's new room was almost right across from R1's room, divided only by a narrow hallway. Facility's census also shows that R2's new room was in close proximity to R1's room.

On 3/3/21 between 10:30 AM and 11:00 AM, on the third floor of the facility, residents and staff were observed. V7 (Social Services Director) was asked if R1 and R2 were roommates before the incident. V7 stated they were not roommates, and she was not sure of which room R2 was before being moved to another room. V8 (LPN, Licensed Practical Nurse) was asked the same question, and V8 stated R1 and R2 were roommates before the incident, and R2 was moved to another room after the incident. V8 stated she had one CNA (Certified Nurse Assistant) working

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with her on the third floor with a census of 44 residents. V7 then said she apologized for giving the wrong information about the resident's room. Since V7 did not know about the two residents' room situations, V7 was asked about which social worker was responsible for R1 and R2. V7 stated V6 (PRSC- Psychiatric Rehabilitation Services Coordinator) was responsible for the whole third floor and that each floor has a PRSC.

On 3/3/21 at 11:25 AM, V6 was interviewed. V6 stated, "I am the social worker for the whole of third floor, yes, about 44 residents". Inquired from V6 how she is able to provide individualized psychosocial services to so many residents, V6 did not respond. V6 further stated, "I called the Administrator because (R2) was intoxicated and asking his roommate for sex. I saw (R2) walking naked and talking loud and inappropriate. The administrator told me to move (R2) and we moved him to another room." V6 was asked about records of psychosocial therapy provided to R1 after the incident. V6 stated she does not have any records of 1:1 therapy for R1. V6 added she did not speak to R1 after the day of the incident since she already told the resident to let her know if there's any further problems. V6 explained she does have any records different from the statement she wrote to the Administrator. Review of R1's records shows that the progress notes written by social services staff after the incident were focused on whether or not R1 initially reported being touched inappropriately. R1's progress notes, dated 2/24/21, written by V11(PRSC) states, "Resident informed to notify staff if he has any issues." V6 did not acknowledge since R1 has a diagnosis of Major Depression, and has just experienced such unwanted sexual touch, he could be going through post-traumatic stress and he is not likely

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to seek out emotional support/help from staff. Rather, staff should go and seek out the resident, and have a 1:1 therapy session with the resident to identify any emotional issues that would otherwise not be identified if they did not purposely provide a 1:1 therapy.

On 3/3/21 at 11:40 AM, V7 was interviewed about the incident and about the records of any 1:1 therapy or assessment they did for R1 after the incident. V7 stated she did not talk to R1 after the incident because it was a Friday evening, and the Administrator was informed immediately it happened, and the Administrator started the investigation. Inquired from V7 about records of the psychosocial interventions provided to R1. V7 stated they don't always document it. V7 stated V6 is the PRSC for the third floor. Again, V7 was asked for a psychosocial assessment for R1 and R2 following the incident

On 3/3/21 at 12:25 PM, V3 (LPN, Licensed Practical Nurse) who was R1's nurse on the day of the incident stated, "I was at the nursing station and I heard yelling in his room. It was (R1) yelling. He told me that (R2) was walking around naked and asking him for sex and to see his penis. (R1) said that (R2) kept asking to see his penis. The social worker called the Administrator and we moved (R2) to another room. I saw that (R2) was intoxicated with alcohol, and he admitted to drinking."

On 3/3/21 at 12:34 PM, V4 (CNA, Certified Nurse Assistant) stated, "I wrote a statement, (R2) was drunk and acting out, asking his roommate for sex."

V1 (Administrator) had earlier presented the initial and final reports of investigations that were sent

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to the State Agency. This report shows that the incident happened on 2/19/21 at 6:45 PM, when R1 yelled from his room. In this report, some staff members' statements written during the facility's investigation include V3 (LPN, Licensed Practical Nurse), V4 (CNA), V5 (Security Staff), V6 (PRSC, Psychiatric Rehabilitation Services Coordinator), V7 (Social Services Director), and V9 (Security Staff). All of the statements show that R2 was drunk and was sexually inappropriate with his roommate, R1.

V7 later presented the following: An assessment/progress note, dated 12/10/2020 (two months before the incident), for both R1 and R2; R1's care plan with latest entry on 9/6/2020; R2's care plan with latest entry on 10/21/2020. These assessments and care plans presented showed there were no updates or revisions for either R1 or R2, to address the unusual incident that happened on 2/19/21.

In one of the staff's statements, in the facility's investigation presented by V1, V9 (Security Staff) wrote in a statement, dated 2/24/21, quoted in part: "I was the security guard that worked last Friday afternoon and I went to the third floor when they called us to come upstairs because of (R2) being drunk. (R2) was loud, walking around naked." V9 also wrote, "I worked on Saturday morning and saw both residents talking to each other and no issues or problems came out of that, so I thought it was fine."

On 3/3/21 at 1:00 PM, V2 (Director of Nursing) presented R1's Physician Order Sheet (POS), dated 3/3/21 at 12:40 PM, with an order for Diphenhydramine 50 mg (milligram) by mouth daily at bed time as needed to help R1 sleep. V2 explained she was just notified R1 complained of

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S9999	Continued From page 7 sleep disturbances and nightmares. On 3/3/21 at 1:15 PM, V1 was asked about the facility's bed availability. V1 stated the current census is 126 and their capacity is 144; with 5 residents in the hospital, they have only 13 beds available. At this time, V1 was notified about the proximity of R2's new room on the same third floor with R1's room, and the possibility both residents could actually still see each other and have contact with each other by just standing at the door of their rooms. Also, V1 was informed about R1 still having sleep disturbances and nightmares from the incident, and R1 gets scared when he meets R2 in the hallway. V1 responded the regulation did not say how far apart the residents should be separated. V1 later stated she would move R2 to the fourth floor. The surveyor explained to V1 the sexual abuse allegation incident happened 11 days ago, and it is of concern that both residents still see each other in the hallway and were not separated in a way to prevent further contact with each other. On 3/4/21 at 11:56 AM, V12 (Nurse Practitioner) was interviewed regarding the incident and what her expectations were for the residents after the incident. V12 stated, "I would protect the victim, I would separate them and follow whatever the policy says." V12 also explained the facility tried to get R2 enrolled in a program to help him overcome drinking. On 3/8/21 at 12:59 PM, V1 stated that R2 had been moved to another floor after the surveyor expressed the concern to her. Facility's undated policy titled "Abuse Prevention Program" states in part: Federal and State laws and regulations mandate that a nursing home	S9999		

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S9999	Continued From page 8 resident has the right to be free from verbal, sexual, physical, and mental abuse, exploitation, corporal punishment, and involuntary seclusion." Facility's "Abuse Prevention Training Program Protocol" states under "Protection": The facility will remove any alleged perpetrator(s) of abuse or neglect from any further contact with the residents pending an investigation. #B states in part: If the alleged perpetrator is a resident, the resident will be separated from the alleged victim and the resident's condition will be evaluated as soon as reasonably possible to determine the most suitable therapy and placement for the resident. Facility's document, dated 5/03, titled "Psychosocial Coordinator" under the "Purpose of the Position", states in part: The primary purpose of this position is to integrate, coordinate, and monitor each resident's specialized services program of a specific case load of residents in accordance with current federal, state, and local standards, guidelines, and regulations, to assure that medically related emotional and social needs of the residents are met and maintained on an individual basis. #17 states: Assure all progress notes charted are informative and descriptive of the services provided and the resident's response to the service. (A)	S9999		