STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE CLIFTON	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2168221/IL139973 2168222/IL139974	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)3) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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 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 regulations are not met as evidenced by: Based on record review and interview, the facility failed to supervise a resident (R2) with known sexual behaviors to ensure protection from non-consensual sexual abuse of another resident (R1), and failed to protect a vulnerable cognitively impaired resident (R1) without the mental capacity to consent to sexual activity. This failure	S9999		

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S9999	Continued From page 2 affects two (R1 and R2) of five residents reviewed for sexual abuse in the sample of 17. Staff allowed R2 unrestricted access to R1, resulting in R1 being sexually abused by R2. Findings include: R2's Census Detail documents R2 was admitted to the facility on 10/13/21. The facility's Initial Report to the Illinois Department of Public Health dated 11/3/21 documents the facility received a report of possible sexual abuse between R2 and R1 related to resident to resident sexual contact without consent. R2's Nurse's Notes dated 10/29/21 at 7:30 am, documents, "Resident (R2) was witnessed walking down hallway with penis exposed and hand on penis. Counseled regarding not to expose self and zipper zipped with no problem from resident." R2's Nurse's Note dated 11/2/21 at 1:42 pm, document, "Resident (R2) was in hallway trying to pull down his pants, he had his hands down his pants, (Director of Nursing, V2) redirected him to his room and he tried to get me (V2) to go in first, redirected him to go first and he told me to go away. I (V2) prompted him to go to the bathroom to use the restroom and if he needed to masturbate to do this in his room with the door closed for his privacy and others." R2's Care Plan, dated as initiated 10/19/21 with revisions through 11/4/21, does not document any new targeted interventions related to R2's sexual behaviors or wandering as documented in R2's Nursing Notes on 10/29/21 and 11/2/21.	S9999		

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S9999	Continued From page 3 R2's Nurse's Note dated 11/3/2021 at 8:40 pm, documents, "I (V12, Licensed Practical Nurse) was notified by CNA (V6) that this resident (R2) was in another female resident's (R1) room. It was observed that he (R2) had his pants down and his penis was in female resident's (R1) mouth. Resident was immediately separated from female resident and placed on 1:1 (one to one) supervision with CNA. Resident stated that "She (R1) asked for it." Skin assessment completed, no injury or bite marks noted. Administrator notified, resident (R2) sent to ER for evaluation." On 11/9/21 at 12:40 pm, V2, Director of Nursing, confirmed, No new targeted interventions had been initiated for R2's care plan regarding R2's sexual behaviors after the first 2 incidents on 10/29/21 and 11/2/21, and no new interventions were placed into R2's care plan until 11/4/21, after R2's discharge. R1's Minimum Data Set dated 10/15/21 documents a Brief Interview for Mental Status as 00 out of a possible 15, rating R1 as severely cognitively impaired. R2's Minimum Data Set dated 10/20/21 documents a Brief Interview for Mental Status as 12 out of a possible 15, rating R2 as borderline between cognitively intact and moderate cognitive impairment. On 11/5/21 at 9:57 am, V6, Certified Nursing Assistant stated, "On 11/3/21 at 8:36 pm, as I was walking down the halls checking on residents, I witnessed (R2) with his pants unzipped and his penis was in her (R1's) mouth, his right hand was on her (R1's) head forcing her head on his penis. (R2) was in her (R1's) room, standing over (R1's)	S9999		

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S9999	Continued From page 4 bed, one side of her depends (incontinence undergarment) was off and one of (R1's) legs was over the edge of the bed, I yelled and told him (R2) to get out of her room he cannot be doing that, his penis was still in her mouth and he didn't remove it until I physically moved him out of her room and took him back to his room." V6 further stated, "After we got back to (R2's) room, I told him I would have to report his behavior and he started saying that he needed to get his shoes and coat on and get out of there before the police came, then he called his son on the cell phone to tell him to come get him out of there." V6 continued, "(R1) in no way has any capacity to consent to such an act, but (R2) is alert, he had to walk right by the rooms of 5 female residents who are alert and oriented to get to (R1), the vulnerable resident." On 11/5/21 at 12:48 pm, V9, Emergency Room (ER) Nurse, stated, "I was the ER nurse when (R1) came into the ER on 11/3/21 and she was alert only to herself, she did not know why she was in the ER or why her kids would have sent her there, did not realize she was a resident in a nursing home, didn't remember anything about any incident even after I told her what had happened and why she was there." V9 continued, "She did have redness on her left cheek and behind her left ear which I took pictures of. At her family's request I did do a gonorrhea and chlamydia swab test on her throat but I do not have the results of those yet." V9 further stated, "I also did see (R2) when he came to the ER and he also had dementia among his diagnoses but he was much more cognitive than (R1). "He (R2) knew he was in a hospital and that he wore glasses and didn't have his glasses with him, and that he had called his son on the cell phone before coming to the hospital." V9 further stated,	S9999		

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S9999	Continued From page 5 "He (R2) was unwilling to tell me why he was at the ER, but at one point he did say that the staff at the nursing home thought he had exposed himself to someone at the nursing home." V9 concluded by stating, "There is no way possible (R1) could consent to a sexual act, she really couldn't make an informed consent to anything because of her cognitive status." On 11/5/21 at 2:45 pm, V11, Family Member of R1, stated, "(R1) is a very compliant person, if someone says to her, "Lets go do this," then she is going to go do this, but she in no way has any kind of capacity to consent to anything sexual." On 11/9/21 at 10:20 am, V2, Director of Nursing, confirmed, "(R1) does not have the mental capacity to consent to sexual activity." The facility's Abuse Prevention and Reporting Policy dated 11/28/16 documents, "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation." "It (abuse) includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled by the use of technology." "Sexual abuse is non-consensual sexual contact of any type with a resident. Generally, sexual contact is non-consensual if the resident lacks the cognitive ability to consent." "A"	S9999		