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	IL6000483	A. BUILDING: _____ B. WING _____	C 09/06/2022

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S 000	Initial Comments Complaint Investigation 2276700/IL150425	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1220b)3) 300.3240c) 300.3240f) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence,	S9999		

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S9999	Continued From page 2 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 observation, interview, and record review, the facility failed to protect R1, a severely cognitively impaired resident from sexual abuse by a male resident R2 with a history of inappropriate sexual activity. The facility failed to implement a plan to prevent further abuse to R1 once R2's behavior was identified. The facility failed to implement their abuse policy by not investigating, reporting, protecting a confused female resident from sexual abuse by a male resident with known history of sexually inappropriate behavior This applies to R1 a severely cognitively impaired female resident who was unable to give consent for sexual activity by R2. The findings include: The EMR (Electronic Medical Record) shows R1, an 84 -year-old female and was admitted to the facility on 11/28/2018. R1's diagnoses included but not limited to dementia, major depressive disorder, anxiety disorder, visual loss, and other specified mental disorder due to physiological disorders.	S9999		

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S9999	Continued From page 3 The MDS (Minimum Data Set) dated 5/18/2022 and 8/16/2022, shows R1 BIMS (Brief Interview Mental Status) score of 6/15 (very severe impairment in cognition). The MDS also shows that R1 had exhibited mood behavior of feeling down, trouble falling asleep, trouble concentrating on things and moving or speaking slowly. The MDS further shows that R1 requires limited assistance with 1-person physical assistance for bed mobility, transfer, dressing, toilet, and hygiene. R1 requires supervision for walking in and out of her room. The psychiatrist's notes dated 10/9/2021, 11/21/2021, 12/05/2021 shows the same assessment that shows R1 is oriented to self, with confusion and easily distracted with flight of ideas. The Social Service Notes dated 11/16/2021, 2/6/2022, 5/16/2022, 8/14/2022 shows R1's quarterly assessments by the social service which shows the same and described R1, a female diagnosed with dementia, major depressive disorder, anxiety, and delusional disorder, alert, stable, able to make her needs known and ambulates on unit independently. The notes shows that R1's BIMS score of 6/15, which indicates symptoms with severe impaired cognition. Further review of social service notes shows that on 12/6/2021 that R1's family was informed that R1 be moving to 2N (designated Dementia Unit) today since R1 has been seeking exit areas and "(R1) needed to go find her white cat." The facility's sexual allegation report dated 8/22/2022 shows that V4 (Nurse Practitioner) reported to V1 (Administrator) an allegation of sexual abuse by R2 on R1.	S9999		

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The hospital ED (Emergency Department) Record dated 8/22/2022 at 11:03 P.M., shows R1's reason for visit was "sexual assault." There was no further documentation regarding R1's visit from the hospital. R1 had returned to the facility early morning of 8/23/2022.

The nurse' progress notes shows that on 8/22/2022 at 10:09 A.M., R1 was sent to the hospital for further evaluation in relation to allegations of unwanted physical contact. R1's family member made aware, and V4 (Nurse Practitioner). On 8/23/2022 at 2:30 A.M., R1 came back to facility.

On 8/26/2022 at 11:14 A.M., V4 (R1's Nurse Practitioner) said that on 8/22/2022, a resident's family member informed V4 that R2 sexually assaulted R1, in R1's room, and that R2's pants were pulled down. V4 said that she immediately informed V1 (Administrator) and sent R1 to the hospital for evaluation. V4 said that there were no signs of rape when R1 was evaluated at the hospital since it was undetermined as when the alleged sexual assault happened. V4 stated that according to the resident's family member, this sexual abuse had been going on for quite some time. V4 said that both R1 and R2 are her patients. V4 described R1 as "pleasantly confused, is not aware of what is going on, is not aware enough to protect herself from abuse and is not able to provide her consent for sexual activity." V4 added that R2 is male resident who is alert, no mental history, and is aware of what he was doing, alert and oriented times 4.

R3 was the roommate of R1 from January 2022 until August 11, 2022. R3 is an alert and oriented female resident who was interviewed on

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8/26/2022 at 11:30 A.M. R3 stated that almost every day around 8:00 P.M. to 9:00 P.M., R2 would sneak into the room. R3 described R2 as being "smart" and would take advantage of the time when nursing staff was passing medications, giving showers, picking up dinner trays or helping other residents go to bed. R3 said she would get startled when R2 came into her room since she was either sleeping or watching TV. R3 added that she would notice R2 suddenly just standing inside their room. R3 said she gets awaken with overpowering smell of R2's cologne. R3 also said that R2 also wears his "cranberry colored silk pajama" every time R2 comes into their room. R3 also said that with a loud tone of voice, R2 would say to her "It is my right to visit my friend (R1), so do not complain." R3 also said that R2 would pull the privacy curtain every time he is with R1, on R1's side of their room. R3 also added that R2 spent long hours with R1 in their room and does not know what they were doing since the curtain was closed and she also turned her TV on, so she did not hear anything. R3 said that R1, is very isolative, withdrawn and does not really believe she understands what R2 is doing to her. R3 added that she tried to ignore it, but all the staff know what is going on between R1 and R2. R3 went on to add to talk to V16 (Nurse) and other staff members since they know what is going on between R1 and R2. According to R3, R2 spent long hours with R1 who cannot say anything, is confused and does not know what is going on.

V17 (CNA/Certified Nurse Assistant) was interviewed on August 26, 2022, at 7:00PM. V17 stated that sometime around the end of May 2022, she saw someone lying in R1's bed wearing "cranberry-colored pajamas" and the privacy curtain was partially pulled. V17 stated that R1 did not own that colored pajamas so she

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went to check on R1. V17 stated that R2 was in R1's bed and R2 was kissing R1 while R2's arms were on top of R1's breast and chest area. According to V17, R1 was passive, confused and not aware of what was going on and R2 kept kissing R1 and telling R1, "you are so pretty, I love you, I really love you." V17 stated she told R2 to stop and ran out of the room to get the charge nurse (V16). V17 reported everything to V16 and told V16 that R2 was abusing R1 because of R1's impaired judgement.

V16 (Nurse) was interviewed on August 26, 2022, at 7:30PM. V16 stated that sometime around the end of May 2022 V17 informed him that R1 and R2 were in bed together. V16 described seeing R2 lying in bed next to R1 with R2's arms on top of R1's breast area and R2's right knee on top of R1's lower extremities. V16 stated that R1 was awake but not responding and was unaware of what was happening. V16 also stated that R1 was confused and R2 took advantage of her. V16 stated that R2 was pretending to be asleep. V16 then called V1 (Administrator) and V1 told V16, "okay, just keep an eye on him (R2). V16 indicated that he was surprised about V1's response since it is not always feasible to keep any eye on R2 because of the number of residents they need to care for. V16 described R2 as "sneaking", since he would take advantage of the time when staff were too busy to go into R1's room.

On 8/27/2022 at 10:45 A.M., V19 (CNA) said that he had seen several occasions when R2 was lying in bed or sitting at edge of R1's bed while R1 was lying in bed. V19 said that "(R1) is confused and cannot give consent for sexual activity, and for (R2) sitting on (R1's) bed is inappropriate especially that (R1) was lying in bed and does not

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know any difference." V19 said that this had occurred from June, July, and August 2022. V19 said that he thought that this inappropriate sexual manner was already reported to V1 but was wondering why it is still an ongoing issue with R2 going to R1's room, with no further plan or supervision.

On 8/27/2022 at 11:00 A.M., V18 (Registered Nurse) said that on 8/10/2022 around 8:30 P.M., R2 was sitting at R1's bed while R1 was lying down. V18 said that "this is sexual abuse, because (R1) cannot give consent, is confused and (R2) was taking advantage of R1 that was sexual in nature." V18 said that she immediately called V1 and reported the sexual abuse. V18 said she also informed V2 (Director of Nursing) via text. V18 said she was surprised that V1's response was "Okay."

On 8/27/2022 at 11:30 A.M., V2 stated that V18 had texted her on 8/10/2022 that R2 was sexually inappropriate with R1. V2 said that R2 was sitting in R1's bed while R1 was lying down, and privacy curtain was pulled. V2 said that they instructed V18 to report to V1. V2 also said that the facility did not have a plan for monitoring, supervising, including possible treatment for any possible outcome of this sexual abuse. V2 said there was no investigation done after she was made aware of the 8/10/2022 incident. V2 said that also aside from moving R2 the next day to the second floor, the plan of care had no revisions regarding how R2 would be monitored to ensure protection of R1 and other female residents who are cognitively impaired.

On 8/27/2022 at 11:45 A.M., V20 (Nurse) said that R2 is alert and oriented times 4. V20 said that R2 "likes women, he always says to R13 that

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she is his wife and that R13 was upset about being called his wife." V20 also said that R12, who is ambulatory, and is deaf, always spends time in R2's room, and they close the door. They stayed there for hours, and sign postage made by (R2) not to enter the room and always knock." V20 said that "I don't know what they do there the inside room, but I guess that R12 knows what she was doing." V20 also said that R2 moves freely about and comes and goes out of his room.

On 8/26/2022 at 12:30 P.M. and on 8/27/2022 at 9:30 A.M., R1 was observed in her room on the second floor. R1 was observed flipping pages of her book non-stop and was not trying to find a page. There were times that R1 just stared blankly with a flat affect. When asked how she was doing, R1 said, "I don't know, I don't know, I don't know."

On 8/26/2022 at 1:00 P.M., R2 was in his private room on the first floor. R2 said that he was alleged of inappropriate sexual behavior. R2 said that " I will never do that, I am very active, socializing with other residents planning a concert for the Labor Day. I keep myself busy planning what songs for the concert and busy with my paintings." On 8/27/2022 at 10:00 A.M., R2 denied going to R1's room. Later in the interview, R2 suddenly changed his statement and said" Yes, I go to her (R1's) room, nothing else." R2 was ambulating with a steady gait when observed walking inside his room.

On 8/27/2022 at 2:00 P.M., V1(Administrator) said that she was notified by V16 (Nurse) sometime in May of 2022 and V20 (Nurse) in August 2022 regarding R2 being sexually inappropriate to R1. V1 said that she did not investigate these allegations of sexual abuse not

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S9999	Continued From page 9 until V4 had informed her on 8/22/2022. On 8/28/2022 at 1:50 P.M., V2 said that all the sexual abuse allegations were reported to V1. V2 added that the reported sexual allegations made since May of 2022 and August 10,2022 were not investigated and were missed, and she had informed staff to let her know any allegations of abuse. The EMR shows that R2, a 63-year, old male admitted to the facility on 1/11/2018. R2's diagnoses included but not limited to hemiplegia and hemiparesis following cerebral infarction. diabetes mellitus, major depressive disorder, unspecified viral hepatitis, and insomnia. The MDS dated 4/25/2022 and 7/22/2022 shows R2's BIMS score of 15/15 indicating that R2 is cognitively intact. R2 had no range of motion impairment. There was no evidence that any of these allegations were investigated or reported to the state agency. R1's and R2's care plan were reviewed. The sexual abuse/sexually inappropriate behavior were not addressed. There were no interventions how R2 would be monitored to ensure R1, and other confused female residents were kept safe and free from abuse from R2. The EMR for both R1 and R2 including the nurses' notes, psychiatrist notes /physician notes, social services notes show no documentation regarding these sexual advances made by R2 to R1. The facility's policy for abuse latest revision date of 1/2019 shows: "It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a	S9999		

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S9999	Continued From page 10 resident in the facility .... All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will be documented ...Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility ...This policy will define how the investigation of abuse allegations and mistreatment or crimes will be conducted and outline the process of reporting, investigating, and arriving at a conclusion or disposition of the allegation. Inquiries concerning abuse reporting and investigations will be referred to the Administrator and/or the Director of Nursing. The Administrator or DON shall review the findings of the investigation and determine if further training or other corrective action is needed to prevent future occurrences." (A)	S9999		