Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011381	A. BUILDING: ______ B. WING ______	C 08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE MORRIS	1095 TWILIGHT DRIVE MORRIS, IL 60450

(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 2275658/IL149207	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. 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)	S9999		

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These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to protect a resident with dementia from unwanted touching of the breast. The resident is dependent on staff for all care and is not able to communicate with staff.

This failure resulted in sexual abuse and repeated verbal abuse from R8 when R1's breast was touched and from the times R8 repeatedly cursed at her. Using the reasonable person concept, this failure would result in humiliation and degradation.

This applies to 1 of 3 residents (R1) reviewed for abuse in a sample of 23.

The findings include:

According to the Electronic Health Record (EHR) R1 had diagnoses including dementia with behavior, chronic kidney disease, anxiety disorder, dysphagia, depressive disorder, and osteoarthritis.
The Minimum Data Set (MDS) dated 07/06/2022 showed R1 needed extensive assistance of two staff for bed mobility, transfers, dressing, hygiene, and toilet use; and needed extensive assistance of one person for eating. The MDS showed R1's cognition was severely impaired.

A Care Plan initiated 04/11/2022, showed R1 was at risk for aggression from other residents related to behavior of wandering, calling out, yelling, confusion, and the inability to understand others. Interventions to protect R1 include to keep R1

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beyond arms distance from other residents and to monitor R1 for safety when around other residents. The Care Plan showed R1 was a wanderer, was disoriented to place, and had impaired safety awareness. R1 has a behavior problem initiated on 07/28/2022 (during the survey) of yelling for prolonged periods of time when distressed or upset and a behavioral problem of pulling her shirt up in social areas.

A Capacity for Sexual Consent Assessment dated 07/19/2022, at 3:04 PM (one day after the abuse) showed R1 was not aware of who was initiating sexual contact and she could not determine what level of sexual intimacy she would be comfortable with. R1 did not have the capacity to say "no" to uninvited sexual contact and did not have the capacity to consent to a sexual relationship.

On 08/08/2022 at 3:32 PM, V16 (Certified Nursing Assistant/CNA) said on 07/18/2022 around 6:30 PM and 7:00 PM, V16 noticed R1 and R8 sitting in the main dining room near the television. R1 was sitting in her wheelchair with her back toward the window and R8 was sitting in his wheelchair facing R1. R1's pant legs were rolled up above her knees and her shirt was pulled up exposing both breasts. V16 stated R8 had his right hand on (R1's) left leg and I saw his left hand moving away from (R1's) breast. V16 said she went in and took R1 out of the dining room. V16 stated she asked V1 (Administrator) to look at the video camera and verify what she saw had actually happened. V16 said she was nervous to accuse someone if it didn't happen. V16 said nobody had ever told her what was seen on the video footage. V16 said V1 had called her several times to clarify things she wrote in her witness report regarding the incident.

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On 08/08/2022 at 2:41 PM, V9 (CNA) said while V9 was changing R8's incontinence brief on 07/28/2022 around 2:30 AM, V9 was standing on R8's left side and when she rolled R8 toward her, R8 had reached up, "grabbed my right boob and squeezed it twice." V9 stated she was told by the agency nurse to document it in her charting which she did. V9 said she told V3 (Assistant Director of Nursing/ADON) about the incident in the morning and V3 (ADON) giggled and said "Ok, well at least it's not another resident." V9 said she felt like she was sexually assaulted and didn't feel V3 had taken it seriously. V9 stated, "After I told (V3) nobody from the facility has reached out to me."

On 08/11/2022 at 10:49 AM, V12 (Nurse Practitioner/NP Psychiatry) said she had seen R8 on 07/18/2022, but was not sure if the incident had occurred yet. V12 could not remember the date but said she was contacted by V3 (Assistant Director of Nursing/ADON) regarding an incident involving R8 touching R1. V12 stated she believed V3 said it was discovered on camera where they saw R8 reach out and touch R1's breast. V12 said there was another incident in the past one or two weeks in which R8 had reached out and touched a CNA's breast. V12 said she asked V3 (ADON) if a police report was filed and if R8 had been sent out to the hospital for evaluation. V12 stated I told V3 over the telephone R8 should be sent to a local hospital and V3 said she would try. V12 could not recall what was done. V12 said the Psychiatry office has a laminated protocol regarding resident incidents at every nurse's station. When the facility called V12 to notify her of the incident, V12 told them to call the office since she was at a different facility every day. V12 said the psychiatrist could probably make medication

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changes over the phone if needed. According to V12, the protocol after an incident was to call the office, and to call Local Hospital's inpatient Behavioral Health to have the resident sent there so the psychiatrists can still follow the residents. V12 said she did discuss R8's placement in a different facility on 08/01/2022 with V1 (Administrator), V3 (ADON), and possibly also V2 (DON) present. V12 said R8 needed to be separated from female residents and she was unsure if the facility had the manpower to ensure it happens. V12 said R8 had been educated several times about not touching other resident's and he knows it is inappropriate.

A Psychiatric Nurse Practitioner Note dated 08/01/2022, written by V12 (NP Psychiatry) included the staff reported that (R8's) behaviors have deteriorated. R8 was recently observed touching another patient inappropriately. Medication changes were made. "Recommend placing patient in a facility that is more appropriate for his psychiatric concerns."

The undated Psychiatric Hospitalization Protocol provided by the facility showed to call the office (number provided), Fax (number provided) a Petition for Involuntary Admission, Face Sheet, Medication List, and Doctor's verbal admission order; Call (local hospital) for acceptance (number provided); Arrange ambulance transport once patient is accepted by hospital.

On 08/10/2022 11:44 AM, V19 (Social Services Director), said according to the Risk Assessments, R8 had a physical altercation with R11 in the dining room on 06/23/2022 and a physical altercation with R10 who was found on the floor in R8's room on 07/08/2022. V19 said an incident of R8 inappropriately touching R1 was

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S9999	Continued From page 6 dated 07/18/2022. V19 said the Risk Assessment for the incident involving inappropriate touching with R1 did not address whether R1's shirt was up or if R1's breasts were exposed. V19 said she watched part of the video footage with V1 (Administrator) regarding the incident on 07/18/2022. V19 said in the video, R1 was sitting in a wheelchair facing R8 who was also in a wheelchair in the main dining room. V19 said she could not remember if R1's shirt was down or up exposing her breasts. V19 said she did not watch the entire video footage. V1 (Administrator) stopped the video and told V19 to start an investigation. V19 said it was difficult to see R1 and R8 since they were in the back corner of the dining room, however, there wasn't anything blocking the view, she could see a popcorn machine and could see R1 and R8 fully from a side view. V19 could not recall verbatim what R8 had said to her but said he just shrugged his shoulders. V19 could not remember if she asked R8 if he had touched R1. V19 said she did not document her interaction with R8 or any details regarding the incident on 07/18/2022 involving R1. V19 said there was an incident last year on 08/24/2021 of R8 having inappropriate touching with another female resident (R12) who was no longer in the facility. The EHR showed R12 needed extensive assistance of two people for bed mobility and transfers. R12 needed limited assistance of one person for walking and locomotion. R12 used a walker and a wheelchair. The MDS dated 07/21/2021 showed R12's cognition was severely impaired. A Care Plan showed R12 had limited physical mobility. The care plan showed R12 wandered aimlessly, including into other resident rooms and lay on their beds, was disoriented to place, and had impaired safety awareness. The	S9999		

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S9999	Continued From page 7 EHR showed R12 had diagnoses including Alzheimer's disease, dementia, psychosis, schizophrenia, depressive disorder, and anxiety disorder. A Nursing Progress Note dated 12/09/2021 at 4:32 PM (written by DON) showed "This RN was walking behind the long-term nurse's station and witnessed the resident (R8) inappropriately touch a female resident." The note included R8 was directed back to his room and was started on a one on one. RN and the social worker spoke with R8 a few minutes later was asked if knew why they were talking to him. R8 stated "cause I grabbed her hooter". On 08/10/2022 at 4:10 PM, V2 (Director of Nursing/DON) said she was not available during the investigation on 07/18/2022 regarding the incident between R1 and R8 and denied watching the video footage of the interaction. When asked about the allegation of inappropriate intimate touching between R8 and another female resident (R12) which had happened in August 2021, V2 said she was a floor nurse at the time and recalled V8 had inappropriately touched R12. V2 said she remembered walking around the nurse's station and thought she had seen R8 touch a female resident (R12) again around the arm area. V2 stated, "I was overly cautious and thought that was what I saw had happened." V2 could not recall what interventions were put in place at the time in December 2021. V2 said the facility recently moved R8 to another room in the facility with a private room allowing him the ability to "pleasure himself" in private if he had sexual urges. On 08/09/2022 at 12:06 PM, V27 (CNA) said R8 can be rude and will yell and swear at the staff.	S9999		

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V27 said he will also scream at the residents, but it seemed like "he really focused his yelling toward (R1)." V27 said most of the residents will get annoyed with R1 in general, but R1 doesn't understand what she was doing. V27 stated if R1 was in the hallway, R8 will usually scream at R1 to "Get the hell out of the way or get the f*** out of the way." V27 said she has heard R8 call R1 a racial slur. V27 said once R1 was sitting in the doorway to the dining room and R8 told R1 something to the extent of "Move the hell out of the way, I'm trying to get through."

On 08/08/2022 at 12:45 PM, V24 (Registered Nurse/RN) said approximately three weeks ago, R8 had knocked another resident (R10) out of his wheelchair when R10 had wandered into R8's room.

On 08/09/2022 at 12:51 PM, V34 (RN), with V7 (Licensed Practical Nurse/LPN) present, said approximately one year ago there was an incident whereV8 was caught touching another female resident's breasts (R12). V7 and V34 said with the incident of August 2021 they were just told to watch R8 better. V34 said she had received report several weeks ago (around 7/19/2022) R8 had inappropriately touched R1's breast. V7 and V34 said the new intervention with this new incident was to move R8 away from R1's room and to another hallway which still had female residents residing there.

On 08/09/2022 at 2:17 PM, V30 (CNA) said he had started working at the facility in May 2022. V30 said he was not aware of any specific instances but had been told around May or June 2022, R8 had a history of groping female resident's breasts, including R1. V30 said he was not aware of the incident between R8 and R1 on

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07/18/2022.
On 08/09/2022 at 4:12 PM, V29 (RN) said R1 was not coherent and becomes more confused if someone yells at her. V29 said R8 will yell at residents to "Get the f*** out of my way" and will yell at R1 daily. V29 said she will keep a closer eye on R8 since R8 had an incident in the summer of 2021 of touching a female resident's breast.

On 08/10/2022 at 1:56 PM, V35 (CNA) said she was aware of an incident where R8 had touched a female resident's breast. The female resident (R12) was no longer in the facility. V35 said she recently had heard of an incident in which R8 had touched R1's breast. V35 said R1 will pull her top up at least once a day but she does not realize she is exposing herself. V35 said R8 would tell R1 to "shut the F*** up" often.

The Progress Notes for R1 dated 07/18/2022 at 9:25 PM, written by V1 (Administrator) showed "Notified MD, Ombudsman and Morris PD (Police department) of investigation initiated." No description of the incident was documented in the progress notes.

A Skin Assessment dated 07/18/2022 at 9:25 PM written by V6 (RN) showed it was a Weekly Status Report with no new skin issues. No description of the incident was documented in the Assessments.

On 08/10/2022 at 1:12 PM, V37 (Nurse Practitioner/NP) said she was not aware or told of R8 having any inappropriate sexual contact with a female resident. V37 said she had heard R8 had attempted to grab a CNA's breast and they had moved him to another room in the facility. V37 said when she couldn't find R8 in his room on

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8/04/2022, one of the CNA's had said R8 had been moved to another room because he had an incident of grabbing someone's breast. V37 said she did not see or examine R8 that day or any day since then. V37 said she had been seeing R8 for years and recalled psychiatry had made medication changes several years ago because "R8 was going closer to women." V37 said if R8 was getting his strength back and was having more behaviors, then he should probably be in a facility where the male and female residents were separated, and they can treat more mental health residents.

On 08/10/2022 at 2:54 PM, V36 (Medical Doctor/MD and Medical Director) said from what he remembers, R8 has been having one or two behavior episodes with residents and making advances toward staff. V36 said he did not watch the video camera footage of the incident between R1 and R8. V36 said R8 has had these episodes and he had suggested giving R8 fake breasts to keep in his room. V36 said psychiatry should have been dealing with the behaviors and treated as necessary. V36 said obviously R8 was still having issues and believed psychiatry should do an evaluation and determine if R8 needed to be in an inpatient setting or be placed in another facility which would be more appropriate. V36 said he has never been provided with any information from psychiatry regarding recommendations for R8. V36 said he would support sending R8 to another facility if psychiatry had given that recommendation.

A Final Abuse Investigation Report dated 07/25/2022 showed an allegation of resident-to-resident inappropriate touch occurred on 07/18/2022. The report showed a CNA had observed R1 and R8 facing each other in the

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dining room and R1's shirt was pulled up. The CNA called out loudly for assistance and R8 backed away from R1 as the CNA was approaching them. The report included V1 (Administrator) had reviewed the video footage which showed R8 had propelled himself across from R1. "Due to camera view partially obstructed, the only contact that can be seen is (R1) reached out to touch (R8) softly on the arm."

On 08/09/2022 at 4:37 PM, V1 (Administrator) said he had been advised by the Corporate Lawyers he could not disclose the video to the surveyor. V1 said he also had looked this morning and saw the video had only been available for ten days and was no longer available to view.

According to the EHR R8 had diagnoses including chronic obstructive pulmonary disease, insomnia, depression, and schizoaffective disorder. The admission Minimum Data Set (MDS) dated 06/15/2022 showed R8 needed limited assistance for moving around unit and R8 used a wheelchair.

A care plan showed R8 has the potential to be verbally and physically aggressive with poor impulse control. R8 has inappropriate behavior with other residents and staff behavior initiated on 08/25/2021 with interventions including to explain why behavior is inappropriate, remove the resident to another location as needed, R8 returned to the facility with hourly location monitoring for 48 hours to ensure the safety of others, was educated on the importance of personal space which R8 voiced understanding, and was provided a fake breast. An intervention implemented on 09/06/2021 included transferring R8 to a room closer to the nurse's station for

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S9999	Continued From page 12 monitoring. The facility's Abuse Policy dated 04/2022 included Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately. Any forced, coerced or extorted sexual activity with a resident is considered to be sexual abuse. The Abuse Policy will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The facility's Physician-Family Notification Change in Condition policy dated 05/2022 included the facility will consult with the resident's physician or Nurse Practitioner when there is a significant change in the resident's physical, mental, or psychosocial status or a decision to transfer or discharge the resident from the facility. (B)	S9999		