STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: _____ B. WING _____	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

(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 2248122/IL152148	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.3210 t) 300.3240 e) 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect e) 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. (Section 3-612 of the Act) These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent sexual abuse in 1 of 3 residents, (R2), reviewed for abuse in the sample of 6. This failure resulted in R2 being sexually abused by R3. This failure has the potential to affect all 31 vulnerable residents (R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32 and R33.) Findings include: On 10/11/22 at 7:40 AM, V4, Agency Registered	S9999		

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S9999	Continued From page 2	S9999		

Nurse, (RN), stated she is the one that initiated the report on R3, while she was working the ZZZ/XXX hallway on 10/9/22. V4 stated she was getting "prepped for the noon med pass, a family member came to me and said, there's a man touching her and pointed to the sitting area. (R2) was on the couch fully clothed, with an (incontinence brief) on and (R3) had his hands between R2's legs and was rubbing in an up and down motion. I called (V1, Administrator) and he told me the protocol. I called the doctor (R3's) and he put (R3) on one on ones and then we moved him, (R3), to room (another resident room). We sent her (R2) out to the hospital for a rape kit. I'm not sure who the family member was that told me, she was heading out to the patio with her mother. I was told yesterday (10/10/22) that he was on one on ones, then this morning he's on 15 minutes checks when out of his room due to staffing. He (R3) was to be closely monitored prior to this incident." V4 was unable to state what "close monitoring" meant or entailed. V4 stated, she is the only nurse with one Certified Nursing Assistant, (CNA) on R3's hallway (WWW hall). V4 stated there weren't any staff members on the hallway that she saw when she observed the incident on 10/9/22 involving R2 and R3.

On 10/11/22 at 8:10 AM, V2, Director of Nursing, (DON), stated, "It was reported on Sunday (10/9/22) that when (R3) came back from smoke break, the CNA was letting the other residents in, and (R3) was going down the 200 hallway to his room on the ZZZ hallway. (R2) was laying on the couch in the sitting area, off the YYY hallway, and (R3) was touching her (R2), outside of her clothing. A family member, (unsure of whom), reported it to the nurse." V4 stated she was not here when the incident occurred, so she is not sure if R3 was being closely observed. V2 stated

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S9999	Continued From page 3 R3 was moved to room (another resident room), and placed on one-on-ones while awake and 15-minute checks when sleeping, and isn't to be taking any smoke breaks with other residents. V2 stated, "(R3) is to eat in the dining room with one-on-one supervision. The one-on-one observations were changed to 15-minute checks throughout the night." When asked how the staff are doing one-on-one supervision with R3 this morning, when there is only 1 CNA on the hall, V2 stated, "There's supposed to be another CNA coming down here." V2 stated they have cameras in the building, but the sitting room area is not captured on the camera. V2 stated, "I'm trying to get that couch removed, because she (R2) likes to lay on it." V2 left and came back stating another CNA was on her way down to do one-on-one observations with R3. On 10/11/22 at 8:25 AM, V1, Administrator, stated he received a call on Sunday (10/9/22) that "a family member had witnessed (R3) rubbing (R2's) vagina. (R2) was fully clothed at the time. (R2) was sent to the emergency room for an evaluation. (R3) was put on one-on-one supervision." V1 stated prior to incident on 10/9/22, R3 was on 15-minute checks. On 10/11/22 at 10:30 AM, V8, Agency CNA, stated she took the residents out to smoke prior to the alleged incident that took place on 10/9/22, between 10 AM and 11 AM. V8 stated she had let R3 back in the building, but didn't witness anything. V8 stated she was then told that she had to take over V15, CNA's, assignment because V15 had to go provide one on one care with R3. V8 was told one of the residents with the same first name as R3 was "messing with" R2. V8 stated she did not look to see if there were other staff members around.	S9999		

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S9999	Continued From page 4 On 10/11/22 at 11:07 AM, V11, R6's family, stated she was at the facility on 10/9/22, visiting with R6, and as her and R6 were coming up the YYY hallway, heading towards the front patio, she observed R2 lying on the couch and an unknown male was in front of R2, rubbing his hands between R2's legs. V11 stated she does not know who the male is, or if he is a visitor or resident. V11 stated she immediately reported it to the first person she saw, which was a staff member coming around the corner to the right of where they were, unsure of whom the staff member was. V11 stated the staff member went directly to the sitting area, so family and resident, (R6 and V11), went on out onto the patio. V11 stated she has not observed anything like this before when in the facility. V11 stated she (V11) and R6 often visit with R2 when she is sitting/laying on the couch. V11 stated, "(R2) lays on that couch 'a lot.'" V11 stated she did not see any staff on the YYY hall or by the sitting area, until she reported the incident, and staff was coming around the corner on the (ZZZ hallway), which was around the corner where the sitting room could not be seen. R3's Face Sheet, undated, documents R3 has a diagnosis of Unspecified Dementia and Muscle Weakness. R3's Minimum Data Set (MDS), dated 9/7/22, documents R3 has severe cognitive impairment, requires an extensive assist of two with transfers and supervision with locomotion on the unit. R3's Care Plan, dated 8/14/22, documents R3 has sexual behavioral symptoms towards female residents with an intervention, dated 9/19/22, with a discontinuation date of 10/9/22, to be monitored	S9999		

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S9999	Continued From page 5 by all staff to prevent him from entering female resident rooms or being alone unobserved in hallways, resident on 15-minute checks and allow distance in seating other residents around R3, divert resident's behavior by moving him away from females. The intervention, dated 10/9/22, documents R3 was placed on one-on-one supervision, while awake and 15-minute checks while in bed. Resident is not able to self-transfer out of bed and was moved to room AAA close to nurse's station. R3 had the intervention added on 9/19/22 to be monitored by all staff to prevent him from entering female resident rooms or being alone unobserved in hallways, due to a history of sexual behaviors towards female residents. R3 was placed on one-on-one observations on 10/9/22 as an intervention due to the sexual abuse that occurred on 10/9/22 involving R2. R3's Progress Notes document the following: "10/9/22 at 12:27PM by (V4, RN), at approximately 10:40 AM, this nurse was notified by a passing family member that the resident was touching another resident. (V4) went to observe a resident laying on a couch on YYY hall with her legs closed, clothes on while (R3) sat in his wheelchair, reaching between her legs with his hand in motion. (V4) immediately told the resident to stop and removed him from the area in his wheelchair. The Administrator was called and notify of the behaviors observed, between (R3) and (R2). (V4) was informed to call the residents' involved families, and the doctor to report incident. (V4, nurse) called the doctors exchange at 10:59 AM and received a call back at approximately 11:06 AM, who gave an order to place the resident initiating the inappropriate touching on one on-one supervision. POA	S9999		

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S9999	Continued From page 6 contacted with no answer. Voice mail left asking for callback. DON notified this (V4) to call the local police department to file a report of sexual assault, this nurse called the local police department at approximately 11:18 AM, told them of incident and report number given 2xxxxxx, officer on the scene at 11:42 AM to get further information and notified V4 he would also go to emergency room to attempt to gather further information from the victim. DON also wants the resident to be sent to the local emergency room for sexual assault evaluation; 10/09/2022 at 1:37 PM, (V4, Nurse), was notified the doctor placed an order for a new medication, he will be placed on Seroquel, and moved to another hall with continued one-to-one observation, resident is unable to recall the situation that occurred and will continue to be monitored for changes in behavior and mentation; 10/10/2022 10:26 PM, by (V6, RN), Per DON resident is no longer one-on-one at all times. He is one-on-one when awake and 15-min checks when in bed, due to being unable to accommodate one-on-one, because of staffing shortage. Nurse's and CNA's on this unit were not able to provide one-on-one observation, while (R3) was up in wheelchair, but did complete 15-min checks. Nurse was not able to stay on unit due to passing medications on other end of building." R3's Physician Order Sheet, (POS), documents an order dated 10/9/22 for one-to-one observation with staff every shift, needs to be one-to-one with staff at all times. R3's Event for Combative/Aggressive Behavior, dated 10/9/22 at 12:30 PM, documents the following: Describe behavior exhibited: At approximately 10:54 AM ,This nurse was notified by a passing family member, that a resident	S9999		

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S9999	Continued From page 7 looked to be touching on another resident, this nurse observed (R3) sitting in his wheelchair in front of (R2) who was laying on a couch on hall YYY her legs were closed and resident was fully dressed, (R3's) hand was in motion between the legs of (R2), this nurse approached the resident told him to stop the behavior and he immediately did and allowed this nurse to remove him from the area. (R2) continued laying on the couch. Resident was touched inappropriately by the other resident and will need a sexual assault evaluation done by local police department, as well as the emergency room. Prior to the incident, (R3) was outside smoking with peers in his wheelchair then wheeling down the hall. (R2) was up walking around requiring frequent redirection from entering other residents rooms and entering places designated for staff; Was resident or others injured during the behavioral episode: yes; Describe resident/others injured: Residents peer was touched inappropriately without consent; Describe resident's activity before aggressive/combative behavior began: Resident was seen looking for the nurse to get cigarettes to smoke. On 10/11/22 at 8:05 AM, R3 was observed, and is alert to self only. R3 denied being sexually inappropriate or touching other residents inappropriately. R3 stated he doesn't know why he was moved to his current room. R2's Face Sheet, undated, documents R2 has a diagnosis of Alzheimer's Disease, Muscle Weakness, Age Related Debility and Age-Related Cognitive Decline. R2's MDS, dated 7/13/22, documents R2 has severe cognitive impairment.	S9999		

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S9999	Continued From page 8 R2's Care Plan, dated 9/26/22, documents R2 is at risk for abuse/neglect. R2's Progress Notes document the following: "10/9/22 at 12:14 PM by (V4, RN): At approximately 10:40 AM this nurse was notified by a passing family member that the resident was being touched by another resident, this nurse went to observe resident laying on a couch on YYY hall with her legs closed, clothes on while another resident sat in his wheelchair directly in front of her reaching between her legs outside of her clothing with his hand in motion in her private areas. This nurse immediately told the resident to stop and removed him from the area in his wheelchair. The resident is unable to state what was occurring or given any further insight of the situation, she is alert to herself and unaware of surroundings. Resident was last seen by staff walking around in the hall requiring redirection for wandering into rooms and the dining room while it was being cleaned. Administrator was called to notify him of the behaviors observed. This nurse was informed to call the residents involved families, and the doctor to report incidents. This nurse called the doctors exchange at 10:59 AM and received a call back at approximately 11:06 AM who gave an order to place the resident initiating the inappropriate touching on one on one. POA notified at 11:15 AM of the incident. POA was also called back at 11:54 AM to give permission to send to the emergency room for a sexual assault evaluation. DON notified this nurse to call the local police department to file a report of sexual assault. This nurse called the local police department at approximately 11:18 AM, told them of incident and report number given 2xxxxxx, officer on the scene at 11:42 AM to get further information and notified this nurse he would also go to emergency room to attempt to	S9999		

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S9999	Continued From page 9	S9999		

gather further information from the victim. DON also wants the resident to be sent to the local emergency room for sexual assault evaluation; 10/9/22 at 2:06 PM by (V4, RN), POA called back to the facility inquiring about what precautions would be done to ensure that the resident would be free from this happening again. This nurse reassured family that she would be under close observation upon her return from the hospital and the offender was being watched as well. This nurse gave phone numbers to family to call office staff and inquire about the specifics of precautions taken to ensure safety; 10/09/2022 at 5:37 PM Resident has returned to facility from emergency room via ambulance accompanied by two attendants. No new orders. Resident has been wandering from room to 200 hall sitting area and dining room. Denies pain and discomfort. No signs or symptoms of acute distress noted. Frequent checks."

The police report by V21, Police Officer, dated 10/9/22, documents, "On Sunday 10/9/22 at approximately 11:36 AM, I was dispatched to (facility) in reference to a report of sexual assault. Upon arrival, I spoke with (V4, RN), who states a visitor observed a patient with what appeared to be his hands between a female patient's legs. (V4) stated she responded to the area, and observed (R2), lying on her back on a couch in a common area. (R3), sitting in front of the couch in a wheelchair, with his hands between (R2's) legs. (V4) states (R2) was fully clothed and wearing an adult diaper. (V4) stated she wheeled (R3) back to his room where he is being monitored by a certified nurse's assistant (CNA). (V4) stated both (R2) and (R3) have a declined mental ability, subjects will not be able to recall the situation.

The facility "Initial IDPH, (Illinois Department of

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S9999	Continued From page 10 Public Health), Incident and/or Abuse Notification", documents on 10/9/22 at 10:55 AM, staff reports allegation of possible resident to resident inappropriate sexual contact between (R2) and (R3). Residents separated immediately. Administrator notified immediately. Final report to follow. The facility "Final IDPH Incident and/or Abuse Notification", with an incident date of 10/9/22, documents "Based on the results of the investigation, facility was able to substantiate abuse related to inappropriate sexual touching. Care plans updated, chart and medication review completed. MD and POA's notified. Both Residents remain in facility. Both residents have continued daily routines with no s/s of mental anguish or behaviors out of the normal." On 10/11/22 at 8:22 AM, V5, CNA, stated she is providing one-on-ones with R3 today. V5 stated she thinks she is to stay with R3 unless another staff member is with him. V5 stated she was off this weekend (10/8/22 & 10/9/22), so she is not aware of any incidents that occurred during that time. V5 stated prior to the incident on 10/9/22, R3 was supposed to be separated from other female residents. On 10/11/11 at 9:50 AM, V15, CNA, stated she was told on 10/9/22, unsure of exact time, that she had to go provide one on one care with R3. V15 stated she was told, unsure of exact time, R3 was observed touching R2, so he was moved from the ZZZ hall to room (another resident room). V15 stated prior to this incident, R3 was on 15-minute checks, and they were to "keep an eye on him." V15 stated R3 has "been in trouble for this before." V15 stated she did not witness the incident that occurred on 10/9/22.	S9999		

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S9999	Continued From page 11 On 10/11/22 at 11:03 AM, V6, Agency RN, stated it was only her and one CNA working on the WWW hallway for the PM-1 shift on 10/10/22. V6 stated the ZZZ/XXX hall nurse didn't show up for her shift, so she (V6) had to pass medications for the ZZZ/XXX and WWW hallways. V6 stated there was only the 1 CNA on the 400 hall, "I can guarantee, he (R3) did not have eyes on him the whole time. I was told by the DON, (V2), to change him, (R3), from one-on-one care continuously, to only when out of his room, because of staffing and he was in and out of his room and up and down the hallways." On 10/11/22 at 11:40 AM, V2, DON, stated on 10/10/22, the evening shift nurse did not show up for her shift. V16, CNA, was supposed to provide one-on-one with R3 on the evening shift but left. V2 stated either V12, CNA, V14, CNA, or V18, CNA, would have been providing one on one care with R3 on the evening shift 10/10/22. On 10/11/22 at 12:33 PM, V18, Agency CNA, stated she did not provide one on one care with R3 on 10/10/22. The time card reports were reviewed for 10/10/22, 2 PM to 10 PM shift, and documents the following staff were working during that time frame: V22 CNA 2:23 PM - 10:40 PM; V23 CNA 11:18 AM - 6:09 PM; V24 RN 6:48 AM - 4:33 PM; V17 LPN 6:42 AM - 4:06 PM; V25 LPN 7:37 AM - 4:00 PM; V12 Agency CNA 1 PM - 11:30 PM; V26 Agency CNA 2:30 PM - 4:30 PM; V27 Agency CNA 2:30 PM - 10:30 PM; V18 Agency CNA 2:30 PM - 11 PM; V14 Agency CNA 2:15 PM - 10:30 PM; V6 RN 2 PM - 11 PM; V28 LPN 4 PM - 11 PM, V2 DON 2 PM - 6 PM. The timecard reports show after 6:09 PM, there were 5 CNAs,1 RN	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: _____ B. WING _____	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

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S9999	Continued From page 12 and 1 LPN on duty. On 10/12/22 at 8:30 AM, V1, Administrator, provided surveyor with a list of vulnerable residents. The list includes: R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32 and R33. This includes a total of 31 residents. The facility floor plan was reviewed and shows the following: the smoking area where R3 would have been let back into the building on 10/9/22 just prior to the abuse with R2 is at the northwest corner of the building. The sitting area where the abuse occurred is located at the outer corner of the northwest side of the building. R3 would have passed approximately 9 rooms to get to the sitting area with no staff observing R3. The "Abuse Prevention Program" policy, dated 12/16/2016, documents staff will identify residents with increased vulnerability for abuse, neglect, or mistreatment or have needs and behaviors that lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches that would reduce the chances of abuse, neglect, or mistreatment of these residents. (B)	S9999		