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
	IL6010425	A. BUILDING: ______ B. WING ______	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THELMA TERRACE	1450 VIRGINIA AVENUE WOOD RIVER, IL 62095

(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
Z 000	COMMENTS Annual Licensure Survey Inspection of Care Survey	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.3240b) 350.3240c) 350.3240d) 350.3240f) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents, and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) 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. (Section 3-610 of the Act)	Z9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Z9999	Continued From page 1 d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 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, 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 were not met as evidenced by Based on record review and interview, the regulation was not met when the facility failed to ensure implementation of their abuse policy and procedures; failed to immediately report an allegation of sexual harassment to the home management and failed to report the incident to IDPH (State Agency); failed to have evidence of a thorough investigation for 1 of 1 individual (R3) involved in an incident of peer-to-peer sexual harassment for 1 of 1 individual in the sample (R3) who was the alleged victim of sexual harassment when the facility failed to: * Report an incident of peer-to-peer sexual harassment immediately to home administration and management, * Report an incident of peer-to-peer sexual harassment to IDPH (State Agency) and *Investigate an allegation of sexual harassment. Findings include:	Z9999		

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Z9999	Continued From page 2 Policy 5.24 Revised 4/19 documents, "Purpose: A. To identify, review and determine if alleged violations of any individual's rights, including abuse and neglect have occurred. B. To investigate allegations in a professional and impartial manner. Procedure: A. Any home employee or agent who witnesses or suspects a violation of individual rights, peer-to-peer incidents, reasonable suspicion of a crime, abuse, or neglect as well as injuries of unknown source shall immediately report the matter to home management using the following protocol: 2. In order for the incident to be considered reported the employee or agent must speak directly to one of the following managers: Administrator, Executive Director, Chief Executive Officer. C. The home administrator shall report the matter within 2 hours if the event that caused reasonable suspicion resulted in bodily injury to an individual or within 24 hours if the event that caused reasonable suspicion did not result in bodily injury to an individual and send a written report within five (5) working days to the individual's representative and to the Illinois Department of Public Health. D. The administrator shall call a meeting of the Investigative Committee. E. The Committee members shall review meet to review the allegations, conduct interviews and examine information available that is pertinent to the incident." ISP/Individual Support Plan dated 4/25/22 identifies R1 as a 35-year-old female with diagnoses including Allergies, Migraine Headaches and Obesity who functions at the Mild Level of Intellectual Disability.	Z9999		

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Z9999	Continued From page 3 ISP/Individual Support Plan dated 1/31/22 identifies R3 as a 38-year-old female with diagnoses including Seizure Disorder and Seasonal Allergies who functions at the Moderate Level of Intellectual Disability. ISP dated 8/24/21 identifies R6 as an individual with diagnoses including Inappropriate Behavior, Major Depressive Disorder and Anxiety who functions at the Mild Level of Intellectual Disability. R6's Clinician Report dated 7/7/22 at 8:15 PM documents, "Staff was told by another resident that (R6) had told another resident to wear a certain outfit tomorrow and sit outside and lift her leg so he could see her privates. Staff redirected the resident to another area. That resident (R3) told staff what (R6) had said." The facility was unable to provide evidence the incident from 7/7/22 involving R3 and R6 had been reported immediately to home management (Administrators, Executive Director, CEO) and to IDPH (State Agency) and the incident had been thoroughly investigated. On 7/20/22 at 4:48 PM, E9/DSP (Direct Support Person) was asked about the incident on 7/7/22 involving R3 and R6. E9 confirmed she was working and had been seated at the dining room table with R1, R3 and R6 but moved away. E9 then stated, "(R1) told me she had heard (R6) ask (R3) to wear a certain pair of red shorts so he could take pictures. I told (R6) if the pictures ended up on the Internet, he (R6) was going to be in big trouble." On 7/20/22 at 4:57 PM, R1 was asked to describe	Z9999		

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Z9999	Continued From page 4	Z9999		

the incident that occurred between R3 and R6. R1 stated, "I was sitting at table in dining room with (R3 and R6). (R6) told (R3) to put on her red shorts and go outside and sit on the bench and put her leg up so he could take pictures of her privates."

On 7/21/22 at 10:30 AM, E1/Administrator was asked if she was aware of the incident on 7/7/22 involving R3 and R6. E1 responded, "Yes." E1 was asked if the incident had been reported to IDPH (state agency). E1 responded, "No. because nothing happened."

On 7/21/22 at 12:15 PM, E3/QIDP (Qualified Intellectual Disability Professional) was asked about the incident on 7/7/22 involving R3 and R6. E3 stated, "I remember being at home, getting a call from either (E6 or E13/DSP) reporting (R1) had reported (R6) had told (R3) to wear short red shorts and go outside so he could look at her privates, I called (E1) right away." E3 was asked if she documented the call to E1 or to R3's guardian. E3 responded, "Did not document, didn't have my computer."

On 7/21/22 at 3:50 PM, E13/DSP (Direct Support Person) was asked if she had worked the evening of 7/7/22. E13 responded, "Yes." E13 was asked to describe the incident involving R3 and R6. E13 responded, "Another resident (R1) came to me and told me she needed to talk to me. (R1) said (R6) had told (R3) to wear a certain pair of red shorts tomorrow and sit outside so he could look at her privates." E13 stated she waited until the individuals went to bed then placed a call to E3/QIDP (Qualified Intellectual Disability Professional). E13 was asked if she had notified any of the facility administrators. E13 responded, "No." I called (E3). I figured if I was supposed to

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Z9999	Continued From page 5 something else (E3) would have told me." (B)	Z9999		