Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
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	Investigation of Fac	cility Reported Incident of				
	1/25/22 /IL#143066					
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	SIATEWILITY OF L	ICENSURE VIOLATIONS.				
	3001210b)		1			
	300.3240a)					
	300.3240c)					
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	Section 300.1210 (General Requirements for				
	Nursing and Person					
		provide the necessary care	ļ			
		ain or maintain the highest				
	practicable physical	i, mental, and psychological			1	
	well-being of the res	sident, in accordance with		!		
	each resident's com	nprehensive resident care	1	Vi Vi		
	plan. Adequate and	properly supervised nursing			İ	
	care and personal c	care shall be provided to each			i	
		e total nursing and personal				
	care needs of the re	esident.				
	Section 300.3240 A		Į			
35		ee, administrator, employee or		**		
		nall not abuse or neglect a				
	resident. (Section 2	2-107 of the Act)				
	0	A favor a large of the set of	ł			
	Section 300.3240 A					
		rator who becomes aware of				
,		a resident shall immediately				
		telephone and in writing to		Attachment A		
	the resident's repres			Statement of Licensure Violations	,	
	Debarment (Section	ion 3-610(a) of the Act)				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6011571 02/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1001 EAST PELLS STREET** ACCOLADE HC OF PAXTON ON PELLS PAXTON, IL 60957 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 Section 300.3240 Abuse and Neglect f) A facility that becomes aware of photographing or recording of a resident, without the resident's consent or knowledge, or any other abuse, shall comply with subsections (a) through (e) of this Section. These regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure R2 was not subject to sexual abuse by R1. This failure resulted in R2 having increased anxiety and feelings of shame. R1 and R2 are two of three residents reviewed for abuse in the sample of four. Findings include: R2's Face Sheet dated 2/1/22 documents R2 is diagnosed with Multiple Sclerosis, Obesity, Bipolar Disorder, Depression, and Anxiety. R2's Minimum Data Set dated 12/30/21 documents R2 is cognitively intact and requires extensive assist for bed mobility and locomotion and is totally dependent upon staff for transfers. R2 uses a wheelchair for mobility assistance. R2's Care Plan dated 1/30/22 documents R2 is at risk for changes in psychosocial well-being related to recent episodes with another resident (R1). R1's Face Sheet dated 2/1/22 documents R1 is diagnosed with Cerebral Infarction, Left side Hemiplegia and Hemiparesis, Alcohol Abuse, and Dementia with Behaviors.

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R1's Minimum Data Set dated 12/31/21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			TE SURVEY	
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S9999	documents R1 requires wheelchair for methics can be havior town. The Final Incident . On 2/1/22 at 1:55 Pinal Incident Final Incidents. On 2/1/22 at 1:55 Pinal Inciden	dires supervision while using nobility/locomotion. 2d 1/26/22 documents R1 has ior of displaying inappropriate vards others. Report documents on 1/25/22 in the doorway of R2's room incident report documents. Alert and Orientated M R2 stated R1 lived across displayed would frequently be at her nes per day. R2 stated R1 her (R2) while fondling himself inside his (R1) pants and on ins R1 began masturbating his pants. R2 stated R1 her (R2) door when it was ission and would sometimes into her (R2)room uninvited to a (about 10 times). R2 stated cause R2 often had to call for from her doorway or they ag at R1 and come to help. R2 I him (R1) "to get the f*** re." R2 stated, "when (R1) thile looking at me it made me irty, even though I know I rong." R2 stated R1 invaded	\$9999				
	towards her increase and it bothered her to into her room uninvito. (R2 then began to R1 came to sit at he	stated R1's sexual behavior ed her anxiety significantly that R1 seemingly could come ted anytime he(R1) wanted o cry) R2 stated on 1/26/22 or table in the dining room and her so uncomfortable that she				÷	

PRINTED: 03/10/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING IL6011571 02/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1001 EAST PELLS STREET** ACCOLADE HC OF PAXTON ON PELLS **PAXTON, IL. 60957** SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 couldn't take it anymore and she had to ask to leave the dining room in order to finish her meal. R2 stated she went back to her room after lunch and cried. Later that day (1/26/22) R2 found out R1 was leaving the facility and she hasn't seen him since. R2 stated she feels relieved now that R1 is gone. On 2/1/22 at 12:00 PM V10 Licensed Practical Nurse stated over the last month she has observed R1 a few times, pleasuring himself in public areas in the facility (dining room, nurses station, hallway), make sexual comments to staff. and sitting at R2's door with his hands down inside his pants, pleasuring himself. R2 would put her call light on and ask us to move R1 from her doorway. V10 LPN confirmed she does consider R1's sexual behavior abuse when it comes to R2 because R2 cannot get up and leave, shut her door, or remove herself from the situation without staff assistance. On 2/1/22 at 12:16 PM V7 Licensed Practical Nurse stated R1 would often sit at R2's doorway and would open R2's door if it was closed. V7 stated she was providing care for R2 once and R1 opened the door. Luckily they had R2 covered up and so she was not exposed. V7 stated R1 kept doing it though no matter how many times the staff would tell him to stop. On 2/1/22 at 12:30 PM V4 Certified Nurses

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Assistant stated both R1 and R2 are alert and orientated residents. V4 stated within the last month or so R1 has been sitting in front of R2's door and opening her door and other resident's doors when they are closed. V4 stated R1 does sit in front of R2's door with his hands down his pants and would masturbate. V4 stated at first R1 was easily redirected but after R2 reported an

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S9999	keeping a close eye more aggressive wi R1 would move aro and put his hand do masturbate in front R1 did this five or si would cuss and spit minutes he would be never recognized R now. On 2/1/22 at 1:03 Pi Assistant stated she front of resident's do resident's rooms inchas observed R1 wit touching himself who station in the view of V11 stated she has when the staff were to be redirected. On 2/1/22 at 1:05 Pi Nurse stated when the was told in report	and after the staff began on R1, he became much the his response to redirection. Und the halls and then stop own his pants. R1 would of R2's doorway. On 1/26/22 x times. When redirected he at staff and then 20-30 e doing it again. V4 stated she 1's actions as abusive before the has observed R1 sitting in pors and opening doors to bluding R2. V11 stated she the his hands down his pants alle sitting at the nurses of staff and other residents. Observed R1 open R2's door providing care for R2. R1 had alle came on shift on 1/26/22 that R1 was to be watched and away from other resident's	S9999	DEFICIENCY)		
	rooms and doorways watch R1 closely been been masturbating in During my shift on 1/ going to R2's door at when staff were atterbegan spitting, cursing whenever redirected Certified Nursing Assin front of R2's door vision was a single property of the state of the st	cause the day before he had a front of R2's doorway. 26/22 R1 was repetitively and was being very combative apting to redirect him. R1 and, and yelling at staff. I was informed by V4 sistant that R1 was observed with his hands down his oscene manner. I informed		lu l		v I

increase in R1's sexual behavior and angry

Illinois Department of Public Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 EAST PELLS STREET PAXTON, IL 60957 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FIX (EACH CORRECTIVE ACTION SHOULD BY FIX (EACH CORRECTI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION		E SURVEY	
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confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. (B)		On 2/1/22 at 2:06 Pl Assistant stated she with his hands in his multiple occasions. least twice every time average five days per door to enter into R2 closed for privacy and time that R1 would of uninvited. On 2/1/22 at 2:45 Pl confirmed R2 is a vur- move on her own and assistance for transfit confirmed if staff we or feeling himself see they should have repus on he could investigate to R2's allegation on reported R1 masturb confirmed R2 was up was relieved that R1 V3 stated R2 seeme was a few days prior The facility's Abuse at dated February 2021 affirms the rights of reabuse, neglect, or modocument defines abundant injury or sexu- resident other than a willful infliction of inju- confinement, intimidate resulting physical har	e observed R1 in the hallway is pants, pleasuring himself on V13 stated R1 would do it at the she worked which was on er week. R1 also opened the 2's room when the door was not care. R2 mentioned at that often come into her room M V3 Social Service Director ulnerable resident who cannot not have requires staff fers and mobility. V3 are aware of R1 masturbating xually outside of R2's door corted it to V1 Administrator ate it. V3 confirmed that prior 1/25/22, staff had never to be about the situation and was no longer in the facility. The same documents the facility residents to be free from isappropriation. The same puse as any physical or lat assault inflicted upon a coidental means. Abuse is ary, unreasonable ation, or punishment with					

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