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
	IL6007041	A. BUILDING: ______ B. WING ______	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PA PETERSON AT THE CITADEL	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

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S 000	Initial Comments Fcaility Reported Incident of June 16, 2022/IL 148314	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240e) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

nois Department of Public Health
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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care needs of the resident.

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 requirements are not met as evidenced by:

Based on interview and record review the facility failed to ensure R2 and R3 were free from sexual abuse by R1 and failed to have interventions in place for R1 who had known sexual behaviors. This applies to 3 of 4 residents (R1, R2 and R3) reviewed for abuse in the sample of 5.

The findings include:

On June 27, 2022, at 11:17 AM, R3 stated, R1 came into her room, stopped in front of her bed, and pulled out his penis. R1 had his penis in his hand and was masturbating. "It made me mad. I don't think I did anything to provoke it." R2 (R1's roommate) stated, when this happened, she was in the bathroom, and she heard R3 telling him to leave. When she came out of the bathroom, R3 told her what happened.

The facility's IDPH (Illinois Department of Public Health) notification/incident report dated June 20, 2022, shows, "Name of resident: R1, Date incident: June 16, 2022, Time of incident: 8:30

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PM, Describe what happened: Staff nurse called abuse coordinator and reported resident R2 stated that R1 entered her room, did not touch her or roommate or talk to them but started touching himself... Final Report."

R2's progress notes dated June 16, 2022, show, "Writer (V8 RN) called V1 administrator to inform him what R2 reported to staff (that R1 came into their room and masturbated in front of R3). R2 stated R1 entered her room at approximately 1930 (7:30 PM). R2 stated she believed R1 began masturbating in front of her..."

R3's progress notes were reviewed on June 16, 2022, there is no documentation of R1 coming into her room and masturbating in front of her.

R1's progress notes dated June 16, 2022, show, "CNA (V9 Certified Nursing Assistant) came to writer (V8 RN) at approximately 1930 this evening to report what R2 reported to her. Writer (V8 RN) went to R2's room to speak with her. R2 stated that R1 entered her room and she believed he began masturbating in front of her..."

On June 27, 2022, at 2:15 PM, V8 Registered Nurse (RN) stated, she was the nurse the night of the incident on June 16, 2022. V9 CNA had come to her and said R3 told her that R1 came into their room, pulled out his penis and began masturbating in front of them (both R2 and R3). When V9 CNA told her about the situation R1 wasn't in the hall and she didn't see him. She went straight down to R2 and R3's room to talk to them. R3 was visibly upset. V8 RN added, she seen R1 masturbating in the TV room before this incident.

On June 27, 2022, at 3:24 PM, V9 CNA stated,

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R1 normally wanders around the unit. She was working by herself that night and saw R1 down by R2 and R3's room. She was busy and continued helping the resident she was with. She heard the call light going off and stopped what she was doing to see what was going on. She was heading towards R2 and R3's room when R3 was coming towards her visibly upset. R3 told her that R1 had come into her room, pulled down his pants, pulled out his penis and started "moving it." V9 stated, she sat R3 down and gave her some water. R1 was at the end of the hall by the time V9 made down the hall. V9 took R1 to the dining room and gave him some ice cream while she went to talk to R2. R2 then explained the same thing as her roommate R3 said. She added, that R1 can be very aggressive so she is very careful with him because he will hit her.

R1's electronic medical records (EMR) list his diagnoses to include: unspecified dementia with behavioral disturbance, schizoaffective disorder, insomnia, unspecified psychosis not due to a substance or known physiological condition and major depressive disorder.

R1's progress notes dated February 13, 2022, show, "Staff found patient (R1) masturbating in public area of unit."

R1's progress notes dated February 16, 2022, show, "NOD (nurse on duty) reports that resident did not sleep last night and continued to be agitated and pacing throughout the halls. This writer (V3 3rd floor manager) contacted psychiatry for potential direct admit due to increasing behaviors."

R1's progress notes dated February 16, 2022, show, "This writer (V3 3rd floor manager) called

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psychiatry and had reception page V7 R1's psychiatrist. Orders received and carried out for direct admit to psychiatry hospital due to increased behaviors and aggression ..."

R1's progress notes dated February 16, 2022, show, "This writer (V3 3rd floor manager) spoke with intake department at psychiatry hospital who stated they, "could not take the patient at this time due to staffing challenges," that "with a diagnosis of dementia the hospital policy was to place on one on one, but they do not have staff and can't take him." Intake coordinator stated she would contact V7 R1's psychiatrist for update. This writer (V3 3rd floor manager) informed MD (medical doctor) in house for visit and requested that he review for potential medication adjustments for managing behaviors."

R1's progress notes dated February 16, 2022, show, "This writer (V3 3rd floor manager) informed SSD (social service department) and IDT (interdisciplinary team) of current situation including nursing being aware to maintain frequent checks and send to ER (emergency room) if unable to redirect for behaviors... This writer requested SSD to consider referral to other facility to manage psych."

On June 28, 2022, at 2:24 PM, V10 Social Service Director stated, the facility did not follow through with the referral to another facility because they felt they were managing his behaviors.

R1's progress notes by V11 Nurse Practitioner dated February 16, 2022, show, " CC (chief complaint): Staff requested for patient to be seen due to aggressive behavior, making sexual advances to residents and playing with himself...

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S9999	Continued From page 5 Assessment/Plan: 3. Hx (history) of depression with aggressive behavior- quetiapine (anti-psychotic medication) changes to 100 mg (milligram) at bedtime and 50 mg at noon, U/A C & S (urinalysis with culture and sensitivity), CBC (complete blood count), CMP (comprehensive metabolic panel) (both lab draws). 4. Dementia with behavior disturbance- U/A C & S, CBC, CMP, quetiapine changes to 100 mg at bedtime and 50 mg at noon." R1's progress notes dated March 3, 2022, show, "Resident in the wrong room. Other resident was upset and both residents started yelling at each other..." R1's progress notes dated March 29, 2022, show, "Resident has been wandering on unit this shift exhibiting sexually inappropriate behaviors. Sitting in recliner in common area near nurses' station, pulling private parts out of pants." R1's progress notes dated May 7, 2022, show, "Patient up walking the halls all night. Patient offered a snack and when the nurse went into the clean utility to find something patient pushed his way through and grabbed a slice of pizza." R1's progress notes dated May 11, 2022, show, "Resident observed with penis in his hand in the common area while watching a movie..." R1's progress notes dated May 20, 2022, show, "Patient was found by staff to be masturbating in common area. When attempted to redirect patient to do activity in private area, became agitated. He stopped for a few seconds and then continued masturbating. Patient was unaccepting of redirection..."	S9999		

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R1's progress notes dated May 22, 2022, show, "Resident observed with penis in hand near nurses' station..."

On June 27, 2022, at 2:15 PM, V8 RN stated, she did not call R1's physician to inform him of what happened (Incident of June 16,2022).

R1's psychiatry progress notes were reviewed from February 21- June 13, 2022, and showed, no mention that masturbation or physical aggression were reported to psychiatry.

R1's EMR (Electronic Medical Record) shows, his psychotropic medications have not been changed since March 14, 2022.

R1's care plan last revised on May 23, 2022, shows, "The resident has a behavior problem (sexually inappropriate in public, masturbating in day room) related to dementia with behavioral disturbance. ... 3/29/22- Wandering and exposing privates in hallway/common areas, 5/21/22- Sexually inappropriate behaviors; AEB (as evidenced by) masturbating in DR (dining room), grabbing food off food cart. Interventions/Tasks: administer medications as ordered. Monitor/document for side effects and effectiveness, anticipate and meet the resident's needs, caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by, Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, provide a program of activities that is of interest and accommodates resident's status."

R1's EMR does not show any interventions were

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put into place for R1's sexual behaviors.

On June 27, 2022, at 11:34, V5 CNA stated, R1 masturbates everywhere, all the time. "He is a big guy, and he will hit nurses. See how small I am? Depends on his moods. We can only redirect him. They don't do anything. He's always been like this."

On June 27, 2022, at 1:16 PM, V3 3rd floor manager confirmed, R1 has sexual behaviors and has been found masturbating.

On June 27, 2022, V8 RN and V9 CNA both stated, R2 and R3 are alert and oriented. They both know what is going on with some forgetfulness.

On June 28, 2022, at 2:24 PM, V10 Social Service Director stated, confirmed that R1 has sexual behaviors of masturbating in common areas. She stated, they had some interventions in place, but they needed to "add more interventions." They had not updated R1's care plan with new interventions as his behaviors were occurring.

On June 28, 2022, at 2:52 PM, V2 Director of Nursing confirmed, she was aware of R1's sexual behaviors. She also stated, it is sexual abuse if a resident is masturbating in front of another resident.

On June 28, 2022, at 3:07 PM, V11 Nurse Practitioner stated, if the facility had reported sexual or aggressive behaviors, she would make some medication changes and consult psychiatry. If they continued to have the behaviors, she would send them out to the hospital.

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