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	IL6009377	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE	1615 SUNSET AVENUE WAUKEGAN, IL 60087

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S 000	Initial Comments Complaint Investigation: 2317743/IL164485	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These Regulations are not met as evidenced by:	S9999		

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Based on interview and record review the facility failed to ensure a resident (R1) was free from sexual abuse from a resident (R2) with known sexual behaviors. This failure resulted in R1 being sexually abused by R2.

These failures apply to 1 of 9 residents (R1) reviewed for abuse in the sample of 9.

The findings include:

R2's admission records dated 8/23/23 showed R2 was admitted to the facility, with diagnoses including a traumatic brain injury (TBI) and schizoaffective disorder, after being transferred from a sister facility. R2's admission records consisted only of R2's demographic sheet and background checks from the previous (sister) facility. No care plan, progress notes, resident assessments, or any documented information, identifying R2's behavioral history, was sent with R2, upon his admission to the facility.

A Nurse Practitioner Progress Note dated 9/1/23, for R2, showed R2 was "a temporary patient as the facility he was staying in is being fixed ..." The note showed R2's history and physical admission assessment, completed by the nurse practitioner, was limited due to "no medical records available from the transferring facility." The note showed R2 was alert, oriented, able to follow commands, and had the ability to propel himself around the facility in his wheelchair.

A Behavior Note dated 9/6/23, for R2, showed, "Provided patient education on keeping hands to self and not trying to poke staff and make them uncomfortable ..."

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A Behavior Note dated 9/7/23, for R2, showed, "CNA (certified nursing assistant) reported to this writer that resident would tell her sexual stuff in Spanish that translates in "I want to get between your legs." Resident also tries to touch CNA in an inappropriate way. Staff continuously educates him to stop but resident just laughs."

A facility incident report dated 9/18/23 showed V7 CNA witnessed R2 touching R1's breasts, in R1's room, on 9/13/23. R2 was immediately removed from R1's room by V7 CNA. The local police, facility administration, and appropriate physicians were notified. The report showed R1 was cognitively impaired due to her diagnosis of Alzheimer's disease. The report showed R1 "is typically not able to make her needs known."

R2's nurses notes dated 9/13/23-9/15/23 showed R2 was transferred to another floor in the facility and placed on 1:1 staff supervision until his discharge from the facility on 9/15/23.

On 9/25/23 at 9:25 AM, a telephone interview was conducted with R2. R2 stated he remembered the incident with R1 on 9/13/23. R2 stated he entered R1's room and touched R1's breasts.

On 9/25/23 at 9:50 AM, an attempt to interview R1 was unsuccessful due to her cognition. When R1 was asked questions, she would provide repetitive verbal responses of "no, no, no" or "ok, ok, ok."

On 9/25/23 at 10:12 AM, V7 CNA stated R2 "would poke at me with his finger and tell me I was pretty" prior to the incident on 9/13/23. V7 CNA stated she reported R2's behaviors to V6 Registered Nurse (RN). V7 stated, "On 9/13/23, I saw (R2) propelling himself down the hallway,

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towards the dining room, but he never made it to the dining room. I walked down the hall to look for him. I saw him in (R1's) room so I walked into her room. (R1) was lying in bed. (R2) was in wheelchair, next to (R1's) bed. (R2) had one hand on (R1's) breast and his other hand was going down between her legs. I immediately wheeled (R2) out of the room and told the nurse. (R1) can't consent to anything. She just babbles."

On 9/25/23 at 9:19 AM, V6 RN stated she was notified by V7 CNA, on 9/6/23, that R2 was touching/poking V7. V6 stated, "I talked to (R2) about it and told him to stop. He just started laughing." V6 stated she reported the incident to V2 DON and documented the behaviors in R2's medical record. V6 stated she did not report R2's behaviors to his physician or nurse practitioner.

On 9/25/23 at 11:45 AM, V14 CNA stated, "(R2) would touch my leg. He always made (sexually) inappropriate comments to me. This happened multiple times. I would tell him to stop." V13 stated she reported R2's behaviors to "a nurse".

On 9/25/23 at 1:50 PM, V3 Licensed Practical Nurse (LPN) stated on 9/7/23, "A CNA reported to me that (R2) was trying to touch her and speak to her sexually in Spanish. I reported this to the DON (V2). (V2) just told me to redirect him. No other interventions were put into place." V3 stated she did not report R2's behaviors to his physician or nurse practitioner.

On 9/25/23 at 11:30 AM, V2 DON stated R2 "was an emergency admission from a sister facility." V2 stated, "We didn't get any verbal report on him. Our corporate just called and asked us to take him. We didn't get his care plan or any behavioral records from the previous facility." V2

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stated she had "no idea" if R2 displayed any sexual behaviors at his previous facility. V2 stated she was informed of R2's sexual behaviors towards facility staff on 9/6/23 and 9/7/23. V2 stated she did not initiate close monitoring of R2 or 1:1 supervision of R2, after learning of his behaviors, because R2 "hadn't done anything to residents at the time, so I told the staff to redirect him and set boundaries. I talked to (R2) about his behaviors. He was laughing. He just said, "I'm a man. I got eyes. I can look." V2 stated she did not report R2's behaviors to his physician or nurse practitioner.

On 9/25/23 at 11:59 AM, V16 Social Services Director stated she was not aware if R2 exhibited sexually inappropriate behaviors at his previous facility. V16 stated, "When (R2) was admitted, we never got a care plan or records from his previous facility. After his behaviors on 9/7/23, I did place a referral to psych for him. We just told staff to keep any eye out for him." V16 stated she did not report R2's behaviors to his physician or nurse practitioner. V16 stated, "In the future, we should report these behaviors right away to the physician. We also need to make sure we get report from the transferring facility before we accept a new admission."

On 9/25/23 at 11:20 AM, V13 Psychiatric/Social Director, from R2's previous facility, was interviewed via phone. V13 stated, "(R2) was transferred out of here due to our building no longer being habitable. Our air conditioning stopped working. We had to transfer all our residents out to other facilities. I know (R2) well. He had a brain injury due to an accident. He has schizophrenia. He was care planned for behaviors of verbal aggression, physical aggression, and for being sexually inappropriate

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towards staff. He has poor impulse control." V13 stated, "I wasn't involved with the actual process of calling report and getting (R2) transferred out. I don't know what records were sent with him when we transferred him out. I don't know if verbal report was called on (R2). We were just in a hurry to get everyone evacuated." V13 stated he did not know if R2's behaviors had been reported to R2's new facility, prior to his transfer.

On 9/25/23 at 10:36 AM, R2's Behavioral Notes dated 9/6/23 and 9/7/23 were reviewed with V12 (Nurse Practitioner for R1 and R2). V12 stated, "This is the first of me seeing these notes. No one reported (R2's) inappropriate behaviors to me. I saw him on 9/8/23. No one reported anything to me even then. I was not aware of any sexual behaviors exhibited by (R2) until his incident with (R1). Had I been notified of his behaviors towards staff, I would have sent him out of the facility, for a psych evaluation, immediately. I would have been concerned about him being a threat to other residents ..." V12 also stated, "(R1) does not have the mental capacity to give consent."

On 9/25/23 at 11:50 AM, V15 (Family of R1) stated, "(R1) does not have the mental capability to consent. If she did, she would have never consented to letting that (incident with R2) happen."

The facility's Abuse policy dated March 2022 showed, "This facility affirms the right of our residents to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment ...This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of

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S9999	Continued From page 7 property, involuntary seclusion, or mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals ...This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish ..." (A)	S9999		