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
	IL6006555	A. BUILDING: ____ B. WING ____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOKOMIS REHAB & HEALTH CARE CENTER	505 STEVENS STREET NOKOMIS, IL 62075

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S 000	Initial Comments Facility Reported Incident of September 21, 2023 IL165017	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3210 t) 300.3240 b) 300.3240 c) 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	S9999	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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resident to meet the total nursing and personal care needs of the resident.

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
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) 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 and to the Department. (Section 3-610(a) of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to prevent, report and investigate sexual abuse for two of three residents (R1 and R2) reviewed for abuse in the sample of 8. This failure resulted in psychosocial harm in that, a reasonable person would react to being fondled in a public setting with feelings of anxiety, distress, fearfulness, and humiliation.

Findings include:

R2's Minimum Data Set (MDS), dated 8/23/2023 documents R2 requires extensive assist with activities of daily living. R2's MDS documents impaired short-term and long-term memory and

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moderately impaired decision-making abilities.

R2's Order Summary Report for Active Orders, dated 10/11/23, documented R2 had diagnoses of Wernicke's encephalopathy, major depressive disorder, alcohol dependence with alcohol induced persisting dementia, and anxiety disorder.

R1's Transfer/Discharge Report, print date of 10/11/23, documented R1 had diagnoses of unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.

R1's MDS, dated 7/17/23, documented R1 had severe cognitive impairment.

The Illinois Department Notification from, dated 9/21/23, documented, "Resident (R1) was found touching Resident (R2) inappropriately. There were immediately separated. Both residents have DX (diagnosis) of dementia."

The untitled form, dated 9/27/23, documented, "IDT (Interdisciplinary Team) conducted thorough investigation and determined that the incident did occur. Resident (R1) was immediately put on 1:1 supervision."

Addendum to Incident, written by V1, Administrator, regarding her phone interview with V12, Licensed Practical Nurse, documented, "Passing meds went to nurse's desk. (R1) was groping her (R2) breast. He was squeezing and massaging her. When asked, he said he was teasing her. I told him he couldn't do that. Immediately separated them. She looked very uncomfortable. Knees to her chest and looked upset. I kept her with me until CNA (Certified

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Nursing Assistant) could lay her back down."

Addendum to Incident, dated 9/26/23, written by V1 while she conducted a telephone interview with V11, Certified Nursing Assistant (CNA), documented, "I caught (R2) and (R1) in the dining room in the dark. (R2) was starting to undo (R1's) pants. I gave report to the nurse." This document did not include a date when this incident occurred.

Statement written by V10, CNA, dated 9/20/23, documented, "Last time this happened, (R1) inappropriately touching (R2), (V8, LPN/Licensed Practical Nurse) told me he's not alert x 3 and because (R2) is known to also touch res (residents), she's just as much at fault, and that (R1) doesn't know it's wrong, but he VERY MUCH does. Last time he asked me if I was gonna get him in trouble for putting 'his hands in the cookie jar'. He said he knows he shouldn't. Tonight, we caught him again and he stated, "he knows she wants it." She didn't look happy and wasn't touching or looking @ (at) him."

Addendum to Incident, dated 9/26/23, written by V1 during phone interview with V10, CNA, documented, "I've caught (R1) three times touching (R2). I was told nothing can be done about it because he is not alert and oriented times three by (V8)."

On 10/5/2023 at 3:00 PM, V1 (Administrator) stated V12 witnessed R1 touching R2's breast at the nurse's station on 9/21/2023. V1 stated she investigated this and found it had occurred. V1 stated V9, LPN, called her and reported the inappropriate touching as V12 informed V9 during report on 9/21/23. V1 stated V12 did not report the occurrence between R1 and R2 at the time it

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occurred. V1 stated she did report it, notify the police, and start her investigation when she was notified. V1 stated during the investigation of the 9/21/2023 incident between R1 and R2, V10 made a written statement of R1 touching R2 three times, and that R1 made comments after the last episode of inappropriate touching that he knew he shouldn't do it. V1 stated she was not notified of these previous occurrences, did not report these, and did not investigate these statements. V1 also stated V11's written statements stated R2 was caught undoing R1's pants on a previous occasion. V1 stated that she did not report this, nor did she investigate this.

On 10/10/2023 at 11:45 AM, V10 states she didn't report the previous incidents regarding R1 and R2 to administration.

On 10/10/2023 at 11:45 AM, V11 states she didn't report the previous incidents to administration.

R2's Progress Note, dated 9/22/2023 at 11:15 AM, documents R2 would make facial expression as if was going to cry with no tears noted. Facial expression changed back to flat facial expression quickly.

R2's Progress Note, dated 9/25/2023 at 5:29 PM, documented R2 would wrinkle face as if was going to cry, but never did. R2's face would return back to normal within a few seconds.

R2's Progress Note, dated 10/5/2023 at 10:18 AM R2 did exhibit facial expression as if was going to cry no tears, noted stopped as quickly as started only lasting few seconds.

R1's Progress Note dated 9/22/2023 documents Social Service Director was notified of R1's

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inappropriate contact with a female peer and 1:1's are being provided.

Facility provided voluntary statement written by V1 (Administrator) documenting V12 witnessed R1 inappropriately touching R2's breast; R1 stated he was teasing R2, and R2 was trying to cover herself; seemed upset. R2 is non-verbal but seemed upset.

Facility Abuse Prevention Policy, dated 11/28/2016, documents this facility prohibits abuse of its residents and to ensure that the facility is preventing abuse of its residents. The Policy documents "Sexual Abuse is non-consensual sexual contact of any type with a resident."

(B)