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
	IL6010441	A. BUILDING: ______ B. WING ______	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

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S 000	Initial Comments Facility Reported Incident Investigation of 09/10/23/IL164904	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b 300.3210t) 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	

Illinois Department of Public Health

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

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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.

These requirements are not met as evidenced by:

Based on interview, and record review, the facility failed to prevent resident to resident sexual abuse for 2 of 8 residents (R3 and R4) reviewed for abuse in a sample of 22. This failure resulted in harm as a reasonable person would not engage in sexual encounters without the decisional capacity to do so.

Findings include:

R3's Face Sheet, print date of 10/02/23, documents R3 has diagnoses of cognitive communication deficit, altered mental status, and dementia.

R3's Minimum Data Status (MDS), dated 10/02/23, documents R3 is moderately cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. R3's MDS documents R3 requires extensive assistance of two plus person physical assist with bed mobility, transfer, and toilet use.

R4's Face sheet, with a print date of 10/02/23, documents R4 has diagnoses of personal history (Hx.) of traumatic brain injury, and Major depressive disorder.

R4's MDS dated 08/18/23, documents R4 is

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S9999	Continued From page 2 moderately cognitively impaired with a BIMS of 08 out of 15. On 10/03/23 at 1:10 PM, V12, Housekeeping stated she was the one who found R3 and R4 in R4's room. She said the door was open but the curtain in the room was pulled so you couldn't see who was in the room until you entered. She said she knocked on the door and there was no response, so she entered the room. V12 stated when she went around the curtain, she observed R3 and R4 both had their genitals out and R4 performing oral sex on R3 while masturbating at the same time. V12 stated she asked them what they were doing and then she went directly to the nurse's station and informed the nurse what was happening in the room. V12 stated the nurse and CNA (Certified Nurse's Aide) went directly down to R4's room and removed R3 from R4's room. She said R3 was taken off the hallway for a couple of weeks and when they brought him back, he went into a room with his wife. V12 stated R4 doesn't know what is going on all the time. The Illinois Department of Public Health Final investigation report completed on 9/15/2023, documents "At approximately 1340 (1:40PM) on 9/10/2023 the north unit housekeeper knocked on the door to (R4's room). When no response was heard, the housekeeper proceeded to enter the room to complete her daily tasks. Upon entering the room (R3) (R3's room identified) was noted in the room of (R4) where the two were observed to be engaged in sexual activity towards one-another. Both residents were observed with their pants undone and sex organs exposed. (R4) was reportedly leaning forward into (R3's) lap attempting to perform oral sex. Upon observing the situation, the unit nurse was notified, and the	S9999		

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S9999	Continued From page 3 residents were separated immediately followed by the completion of full body assessments on both residents with no issues noted. The facility Administrator, Director of Nursing Services, facility MD/Medical Director, and the POAs (Power of Attorneys) for both residents were notified of the occurrence. No concerns were voiced during notifications and agreement with the residents plans of care were expressed. (R3) was placed on 15 min (minute) checks and temporarily re-located to the TCU (Transitional Care Unit) unit in an attempt to ensure closer observation and discourage him from re-entering the room of (R4). A care plan meeting was set with (V13, R4's mother/POA) for 9/14/23 per her earliest convenience. Interviews and investigation were initiated per protocol and an initial report was forwarded to IDPH due to the low BIMS scores for both residents involved. Initial interviews with both residents were completed within 30 min of the event. At the time of the initial interviews, (R3) denied any sexual activity and reported he was in (R4's) room to assist him with his TV (television). (R4) reported no recollection of the event. The facility administrator along with the SSD (social service director) and DNS (director of nursing services) completed follow-up interviews with both residents on Monday 9/11/2023. During the follow-up interviews, (R4) continued to report no memory of the occurrence. (R3), reported that he is 'not gay or bi-sexual' but that he did allow (R4) to unzip his pants and allowed him access to his body. Continued SSD support and follow-up x72 hours remained in place for residents and no long-term negative psych-social issues were observed. The facility SSD completed interviews with multiple staff and residents to determine if there were any past observations of inappropriate sexual behavior with all responses indicating no concern.	S9999		

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On 10/03/23 at 12:20 PM, R4 was questioned about the incident that happened between himself and R3 and he stated he doesn't remember any incident between himself and R3.

On 10/03/23 at 12:50 PM, R3 was questioned about the incident that occurred between himself and R4. He stated something should be done about R4, he just likes to go up and grab people. He said R4 took his phone so he could call his mom and he was just chasing him down to get his phone back from him. He stated nothing inappropriate happened between R4 and himself. He said he didn't do anything to R4 and R4 didn't do anything to him.

On 10/12/23, at 10:09 AM, V13, R4's mother, stated this is very much out of character for R4. She said he would touch female's arms and she would have to remind R4 that he couldn't do that stuff. V13 stated she doesn't feel like R4 is capable of making decisions regarding sexual activity, she said he can barely walk let alone do anything else. She said he likes women and generally doesn't get along with men. She said it was totally shocking that this all happened. She said based on his past he would be more likely to be with a female than a male.

On 10/17/23 at 1:10 PM, V30, Medical Doctor when questioned by this surveyor if R3 and R4 who both are moderately cognitively impaired were able to make decisions when it comes to sexual activity and V30 stated no, they don't. He stated if they are impaired, they can't make a rightful decision. This surveyor repeated the question a second time and V30 stated if you are telling me they are cognitively impaired then they can't make a rightful decision.

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S9999	Continued From page 5 The facility had no documented assessment regarding R3 and R4 decisional capacity to engage in sexual encounters. The facility's abuse prevention policy, not dated, documents "Policy: The facility is committed to protecting the residents form abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual." It further documents "c) Sexual Abuse: This includes, but is not limited to sexual harassment, sexual coercion or sexual assault, or non-consensual sexual contact of any type with a resident." It also documents "Protection: 3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed." (B)	S9999		

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F 000	INITIAL COMMENTS Complaint Investigations: #2347959/IL164749- No deficiencies cited. #2348517/IL165423- No deficiencies cited. #2348573/IL165501- No deficiencies cited. Facility Reported Incident Investigation of 09/10/23/IL164904- F600	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to prevent resident to resident sexual abuse for 2 of 8 residents (R3 and R4) reviewed for abuse in a sample of 22. This failure resulted in harm as a reasonable person would not engage in sexual encounters without the decisional capacity to do so. Findings include:	F 600		11/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/03/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 3 scores for both residents involved. Initial interviews with both residents were completed within 30 min of the event. At the time of the initial interviews, (R3) denied any sexual activity and reported he was in (R4's) room to assist him with his TV (television). (R4) reported no recollection of the event. The facility administrator along with the SSD (social service director) and DNS (director of nursing services) completed follow-up interviews with both residents on Monday 9/11/2023. During the follow-up interviews, (R4) continued to report no memory of the occurrence. (R3), reported that he is 'not gay or bi-sexual' but that he did allow (R4) to unzip his pants and allowed him access to his body. Continued SSD support and follow-up x72 hours remained in place for residents and no long-term negative psych-social issues were observed. The facility SSD completed interviews with multiple staff and residents to determine if there were any past observations of inappropriate sexual behavior with all responses indicating no concern. On 10/03/23 at 12:20 PM, R4 was questioned about the incident that happened between himself and R3 and he stated he doesn't remember any incident between himself and R3. On 10/03/23 at 12:50 PM, R3 was questioned about the incident that occurred between himself and R4. He stated something should be done about R4, he just likes to go up and grab people. He said R4 took his phone so he could call his mom and he was just chasing him down to get his phone back from him. He stated nothing inappropriate happened between R4 and himself. He said he didn't do anything to R4 and R4 didn't do anything to him.	F 600		

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F 600	Continued From page 4 On 10/12/23, at 10:09 AM, V13, R4's mother, stated this is very much out of character for R4. She said he would touch female's arms and she would have to remind R4 that he couldn't do that stuff. V13 stated she doesn't feel like R4 is capable of making decisions regarding sexual activity, she said he can barely walk let alone do anything else. She said he likes women and generally doesn't get along with men. She said it was totally shocking that this all happened. She said based on his past he would be more likely to be with a female than a male. On 10/17/23 at 1:10 PM, V30, Medical Doctor when questioned by this surveyor if R3 and R4 who both are moderately cognitively impaired were able to make decisions when it comes to sexual activity and V30 stated no, they don't. He stated if they are impaired, they can't make a rightful decision. This surveyor repeated the question a second time and V30 stated if you are telling me they are cognitively impaired then they can't make a rightful decision. The facility had no documented assessment regarding R3 and R4 decisional capacity to engage in sexual encounters. The facility's abuse prevention policy, not dated, documents "Policy: The facility is committed to protecting the residents form abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual." It further documents "c) Sexual Abuse: This includes, but is not limited to sexual harassment, sexual coercion or sexual assault, or	F 600		

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F 600	Continued From page 5 non-consensual sexual contact of any type with a resident." It also documents "Protection: 3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed."	F 600		