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
	IL6008106	A. BUILDING: ____ B. WING ____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

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S 000	Initial Comments Investigation of Facility Reported Incident of 5/6/23/IL159990	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)3) 300.3210t) 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	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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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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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.

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Section 300.3240 Abuse and Neglect

e) Resident as perpetrator of abuse. 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 were Not Met as evidenced by:

Based on observation, interview, and record review, the facility failed to do the following in relation to an abuse incident:

A- Protect a resident with severe cognitive impairment (R2) from resident-to-resident sexual abuse for 1 of 5 residents reviewed for sexual abuse in the sample of 8.
B- Report an incident of resident (R1) to resident (R2) sexual abuse to the facility's abuse coordinator for 2 of 5 residents reviewed for sexual abuse in the sample of 8. This failure resulted in a second incident of resident (R1) to resident (R2) sexual abuse, and a failure to report the first incident to the Illinois Department of Public Health (IDPH).

The findings include:

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R2's Admission Record, printed by the facility on 5/18/23, showed she had diagnoses including Alzheimer's disease, aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension), anxiety disorder, and unspecified psychosis, not due to a substance or known physiological condition. R2's brief interview of mental status (BIMS) evaluation dated 2/10/23, showed she had severe cognitive impairment. R2's facility assessment dated 2/13/23 showed R2 has continuous inattention and wandering behaviors that occurred daily and placed her at significant risk of getting into a potentially dangerous place.

R1's Admission Record, printed by the facility on 5/18/23, showed he had diagnoses including, but not limited to multiple sclerosis, cognitive social or emotional deficit, and anxiety disorder. R1's facility assessment dated 1/12/23 showed he was cognitively intact (BIMS score of 15). R1's care plan dated 8/15/22 showed R1 has a history of displaying inappropriate behavior and/or resisting care/services. Specific behavior exhibited was disregard for personal boundaries. R1's care plan dated 4/20/23 showed he attempts to manipulate staff and residents by blaming, criticism and lying.

On 5/18/23 at 12:45 PM, V7 (Laundry staff) said on 5/6/23 she saw R1 lying on his bed and R2's head was under the covers in the area of R1's penis. V7 said she got R2 out of the room and took her to the dining room. V7 said she reported what she observed between R1 and R2 to V13 (Registered nurse/RN) immediately.

On 5/18/23 at 10:45 AM, V11 (Certified Nursing

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Assistant/CNA) said on 5/3/23 she saw R1 and R2 in R1's room. The door was only cracked open a little. R1 was in his motorized wheelchair, and R2 was standing behind the door. V11 said she could only see R2's hair. V11 said it looked like R1 was leaning to peek through the crack of the door to see who was coming down the hall. V11 said she really did not think much of it at the time, so she finished providing restorative services for the resident across the hall and went to a different area of the building. V11 said whenever she would talk with R2, R2 would be confused. On 5/19/23 at 8:23 AM, V13 said the incident occurred on a Saturday. V13 said there were no management staff in the building on the weekend, and no management staff came in during her shifts on Saturday or Sunday (5/6/23-5/7/23). V13 said she was not asked to interview any of the residents, and she did not do an assessment on R1 or R2 after the incident.

On 5/18/23 at 11:05 AM, V10 (Certified Nursing Assistant/CNA) said R1 would sit in the doorway to R2's room at times. V10 said there was one-time R2 told her (V10) that R1 had her bikini bottom and she needed them back. V10 said R2 asked her if it was wrong if her and R1 slept together or got married. V10 said she redirected R2 back to the activity room and wrote a statement about her conversation with R2 and gave it to V2 (Assistant Administrator). V10 said that conversation with R2 happened within one to two weeks before the incident on 5/6/23.

On 5/18/23 at 11:51 AM, V13 (RN) said she received a report from V7 (Laundry staff) on 5/6/23. V7 reported to her that R2's head was under R1's covers and it "looked like she was performing oral sex on him." V13 said about 40

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minutes later that same day, she (V13) was walking down the south hall, looking for R2, because she did not see her in the dining/activity room. V13 said as she was walking down the hall, she looked into R1's room. V13 said R1 was uncovered and R2's hand was holding "something" in his private area. V13 said R1 looked up and saw her coming down the hall and quickly pulled the sheet up over him. V13 said R2 looked her way and then covered R1 with his comforter. V13 said prior to the incident on 5/6/23, R2 was in R1's room often. V13 said she called V4 (DON) after she redirected R2 back to the dining/activity area. At 12:05 PM, V13 said she should have notified V4 around 10:30 AM when V7 told her she saw R2 in R1's room and it looked like she was performing oral sex for R1. V13 said it was an accusation of sexual relations and R2 is not cognitive enough to consent to having sex.

On 5/18/23 at 1:25 PM, V9 (Certified Nursing Assistant/CNA) said she worked on 5/6/23. V9 said she was taking care of a different resident up by V13 (RN) when V7 came up and told V13 that she saw R2 performing oral sex on R1. V9 said V13 observed R2 in R1's room later that day, with her hand (R2's) under R1's covers. V9 said R2 was not moved to a different room at the end of another hall and placed on 15-minute checks until after V13 witnessed the second incident.

On 5/18/23 at 2:53 PM, V8 (RN) said R1 and R2 'hung out a lot.' V8 said they started hanging out in the dining room and then in R1's room. V8 said R2's memory is awful, and she is not cognitively intact. V8 said R2 is not cognitive enough to make the decision to engage in sex.

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V8 (RN) said R2 and R1 should have been separated and the incident should have been reported to V1 (Administrator) or V4 (DON) right away, because that is abuse. V8 said one-on-one supervision should be initiated until told otherwise, for the residents' safety.

On 5/18/23 at 3:26 PM, V5 (R2's Primary Care Physician) said R2 gets very agitated and goes up and down the hallways. V5 said R2 is not of sound mind, and there is no way she can make her own decisions regarding consensual sex. V5 added that R1 is a master manipulator. V5 said the facility informed him about an incident involving R1 and R2. V5 said he found out later that there was a previous incident before the one that was reported to him.

On 5/18/23 at 4:04 PM, V2 (Assistant Administrator) said R2 is not cognitively intact enough to make the decision to consent to sex. V2 added that R1 is in his right mind and knows what is going on.

On 5/18/23 at 4:18 PM, V4 (DON) said V13 (RN) texted her around 11:30 AM on 5/6/23. V4 said she did not see the text until around 12:00 PM (noon). On 5/19/23 at 9:57 AM, V4 said this is the first time that she was hearing that there was about 40 minutes between V7 (Laundry staff) and V13's observations of R2 and R1. V4 said if interventions were put in place after the first incident that V7 observed, it would have prevented the second incident from occurring on 5/6/23. On 5/23/23 at 10:58 AM, V4 said as soon as V7 reported the incident to V13, and R2 was safe, V13 should have reported the incident to V2 (Assistant Administrator/Abuse Coordinator) immediately. V4 said it is time sensitive; to

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protect the resident and report the incident to the state. V4 said staff did not do that in this case. V4 added, "Nothing about this was appropriate."

On 5/18/23 at 4:33 PM, V3 (Regional Director of Operations) said the team at the facility did the interviews for the investigation and sent her (V3) what they had. V3 said she read the interviews, called the facility when she needed clarification, and did the final report for the Illinois Department of Public Health (IDPH). On 5/19/23 at 2:52 PM, V3 said she was only notified of R2 using her hand to pleasure R1. V3 said during the investigation, there was something in the statements about oral sex, which led her to look into it more, to clarify.

V7's written statement regarding the incident on 5/6/23 showed she saw R2 under R1's covers, in the middle part of his body. V13's written statements regarding the incident on 5/6/23 showed she (V13) went down the south hallway to check on R2 and R1 after being told about inappropriate behavior that was witnessed between the two of them earlier in the day. V13's written statement showed she observed R2's hand on R1's penis. The written statement showed she removed R2 from the room and notified V4.

The facility's final incident report dated 5/17/23, that was sent to IDPH showed, "It was reported to the facility DON (V4) on 5/6/23 that the nurse on duty had separated the above residents from an alleged sexual contact. (R1) was located in his bed, and (R2) was noted to be sitting on the bed next to him with her hands under his covers. The nurse immediately redirected (R2) out of the room..."

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The facility's final incident report, sent to IDPH on 5/17/23 did not include the first incident witnessed by V7 and reported to V13 on 5/6/23.

On 5/23/23 at 8:59 AM, V17 (MDS/Care Plan Coordinator) was asked what R1's care plans on personal boundaries was referring to, V17 said R1 was making inappropriate comments to V18 (Director of Therapy). V17 said R1's care plan was also referring to R1 coaxing a resident down the hall, gesturing with his hand for her to come down the hall. V17 identified the resident as R2. V17 said she has seen R1 gesture with his hand to coax R2 down the hall.

On 5/23/23 at 9:19 AM, V18 (Director of Therapy) said she did not feel comfortable working with R1 because the first time she worked with R1 in therapy he made inappropriate comments to her, talking about her in bathing suits and other indirect sexual comments. V18 said if she had to work with R1 again, she would not want to do it in his room without staff present.

On 5/18/23 at 9:50 AM, V4 (Director of Nursing/DON) said R1 is very manipulative and R2 is confused and easy to manipulate. V4 said R2 used to go into R1's room a lot. V4 said on 5/6/23, V13 (RN) reported to her that she had seen R2's hand under R1's covers by his mid-section. V4 said she texted V2 (Assistant Administrator) regarding the incident and called V3 (Regional Director of Operations) to inform her. V4 said then she called V13 back and told her to move R2's room (to a room at the end of the other hall) immediately, to start one-on-one supervision for R2 and to redirect R2 when she tries going down the south hall towards R1's

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room. At 4:18 PM, V4 said R2 had come into her (V4's) office and she wrote her and R2's conversation down and emailed it to V3 (Regional Director of Operations).

The email V4 sent to V3 on 5/9/23 showed R2 asked V4 "When is all this business with me being at the wrong end of the hall going to end?". The document showed V4 asked R2 why she thought it is the wrong end of the hall. R2 replied she was told she was put there because she was getting too touchy-feely with that guy. V4 asked R2 if she was getting too touchy-feely with that guy and R2 said maybe a little, it only happened a couple times. V4 asked what only happened a couple times and R2 said the touchy feely. V4 asked R2 if she had her hands on his privates and R2 responded that she vaguely remembers doing that. V4 told R2 that she also heard there was oral sex involved and asked if that was true. R2 replied "Only once, because I don't really like doing that." The document showed R2 told V4 that she loves R1 and that her and R1 had sex. V4 asked R2 if she meant actual sex, with his penis entering her vagina and R2 replied yes. V4 asked R2 if that is why she was walking around worried that she was pregnant a couple weeks prior? R2 replied, Yes, probably.

On 5/18/23 at 8:08 AM, V6 (Social Services) said R2 has dementia. V6 said since the incident on 5/6/23, some of the CNAs have seen R2 in R1's room and have had to redirect her. V6 said R1 manipulates and will tell you that it is all R2. It is not all R2. On 5/19/23 at 8:53 AM, V6 said R2 has had increased confusion. V6 said you can tell when R2 has increased anxiety because she cries. V6 said she saw R2 sometime after the incident and she was crying. V6 said she asked

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S9999	Continued From page 10 R2 why she was crying, and R2 said she just does not understand. He (R1) keeps saying his name is (R1's name), but I don't understand. V6 said R2 thinks R1 is someone else. On 5/19/23 at 9:05 AM, V14 (Housekeeping) said R2 is constantly going down the south hall, even after the incident. V14 said some days R2 seems kind of with it and other days she says off-the-wall stuff, like I've got to go catch a plane. On 5/19/23 at 1:39 PM, V14 (Housekeeping) said she was in cleaning R1's room. V14 said R1 was telling her that R2 wrote him a love letter and was rubbing his arm. V14 said R1 told her that R2 had left her panties under his pillow. V14 said R1 told her "They are trying to say that I was manipulating her." R2's Social Service note dated 5/2/23 (four days before the incident) showed Resident was in CNA sitting area with pants down wiping herself. Housekeeping asked her not to do this. Resident told housekeeping she had to. The note showed R2 had just come out of R1's room. On 5/18/23 at 9:12 AM, R1 was in his room, sitting in his motorized wheelchair. R1 was alert and cognitively intact. R1 said he never had a relationship with anybody at the facility. When asked about R2, R1 said, "The dementia gal, she has a crush on me. She was making advances at me, thinking I was somebody else." R1 said two times R2 had leaned in to kiss him and she wrote a weird love letter saying she wanted to make love to him and "all kinds of crazy stuff." R1 said R2 had been in his room thousands of times. R1 said normally, R2 would sit at the end of his bed. R1 said "This time she was climbing up on the bed next to me. Her hand was on top of my	S9999		

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covers, rubbing my leg, it was pretty weird." R1 denied any sexual activity with R2 on 5/6/23, or before that date. R1 said sometimes R2 would come in all "hot and heavy." R1 said he could tell "by the way her feet were pointed, how she walked up on him, or how her demeanor was."

On 5/18/23 at 9:30 AM, R2 was interviewed in her room. R2 appeared confused and anxious. R2 said she has not had any relationship with any of the residents at the facility. R2 said she did not go into any of the male residents' rooms and talk to them. R2 said she does not know a man in a motorized wheelchair. R2 said there is no one that she has special feelings for, and she has not had any sexual relations with anyone in the facility. R2 said she did not recall being in a man's room with her hands under his covers.

On 5/18/23 at 9:36 AM, R2 was observed walking down the south hall. R1 was sitting in his motorized wheelchair, halfway down the south hall. R2 stopped when she got to R1 and the two appeared to be talking. At 9:39 AM, one of the CNAs (Certified Nursing Assistants) went down the south hall and redirected R2 to the activity/dining room.

On 5/19/23 at 9:05 AM, R1 came out of his room at the end of the hallway and faced his motorized wheelchair down the hall, sat there for a minute or two looking down the hallway, then went back in his room. R1 repeated this three times between 9:05-9:15 AM.

On 5/19/23 at 2:52 PM, during an interview with V1 (Administrator) and V3 (Regional Director of Operations), V1 said I guess she (R2) is looking for some human connection and we are taking it

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ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

away. V2 said It is a bigger violation of her rights not to have that friendship. At 2:57 PM, V2 said R2's son lets her make some of her decisions, so why not her body. V1 said it feels like if she is not able to make decisions about her own body, it would be wrong. V1 said R2's BIMS score is not much different cognitively than a year ago when she (R2) signed the forms for her son to be her POA (power of attorney). At 3:10 PM, V3 (Regional Director of Operations) said technically there has been no harm. V1 (Administrator) said there seems to be more harm now that we have not allowed them to have that interaction. V1 said both of them had a positive human interaction that progressed, naturally, to a sexual one. V1 said staff stepped in and intervened when necessary and now they (the facility) need to determine whether she (R2) can consent. V1 said she thinks the facility staff made the right decision at the right time and now they (the facility) need to find out if it is okay.

The facility's final incident report, sent to IDPH on 5/17/23, showed on 5/6/23 an alleged sexual contact between R1 and R2. The report showed the nurse immediately redirected R2 out of R1's room. The report showed that during the investigation, R1 stated that he has received hand relief from R2. R2 denied any oral sexual favors or penetration. The report showed R2 believes she is truly in love.

On 5/18/23, R1 and R2's care plans were provided. R2's care plan dated 5/6/23 showed "Resident engaging in inappropriate touching...Place (R2) on 15-minute checks to minimize inappropriate touching, Explore and investigate (R2's) statements surround touching, and pregnancy." R2's care plan dated 5/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 showed "Resident displaying signs of hypersexuality. (R2) reports I think I'm pregnant. (R2 displays signs of affection toward another resident...Remove (R2) to a safer location free from manipulation, intimidation and exploitation (Room change)." R2's Behavior Tracking Records from February 2023-April 2023 showed R2 had wandering behaviors and would enter other residents' rooms. R2's Nurse's Note dated 1/25/23 showed "Resident is hearing people whisper in her ears when no one is there. The voices are telling her there's a bomb in the building and the building is on fire. R1's care plans did not show any interventions regarding inappropriate sexual activities. The last update to R1's care plans that were provided on 5/18/23 was on 4/20/23. No interventions were added to R1's care plans after the two incidents on 5/6/23. R1's Admission Record, printed by the facility on 5/18/23, showed he had diagnoses including, but not limited to multiple sclerosis, cognitive social or emotional deficit, and anxiety disorder. R1's facility assessment dated 1/12/23 showed he was cognitively intact. R1's Task Schedule for May 2023 showed he had behaviors of overstepping boundaries with staff and residents; agitation, yelling and swearing at staff. R1's care plan dated 8/15/22 showed R1 has a history of displaying inappropriate behavior and/or resisting care/services. Specific behavior exhibited was disregard for personal boundaries. R1's care plan dated 4/20/23 showed he attempts to manipulate staff and residents by blaming, criticism and lying. R1's Behavior Tracking Records from January through April 2023 showed behaviors of over-stepping boundaries with residents and	S9999		

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S9999	Continued From page 14 staff, and agitation and yelling at staff. The facility's policy and procedure titled Abuse Prevention Program, with an effective date of 5/2021, showed "Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the Administrator." The policy also showed "VII. External Reporting of Potential Abuse: 1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injures of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures." (A)	S9999		