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S 000	Initial Comments Facility Reported Incident of 3/7/23/IL157882	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3240b) 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 300.3240 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)	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 were not met as evidenced by:

Based on observation, interview and record review, the facility failed to supervise a resident (R1) to ensure residents were protected from non-consensual sexual abuse; failed to complete monitoring documentation of a resident with known sexual behaviors and failed to protect vulnerable cognitively impaired residents (R2 and R4) without the mental capacity to consent to sexual activity from sexual abuse for two of eight residents (R2 and R4) reviewed for abuse in the sample of ten. These failures resulted in R1 engaging in non-consensual inappropriate sexual behavior with R2 and R4. On 12/23/22, R1 was found with R1's hands down the front of R4's pants. On 3/7/23, R1 was found with R1's hands "massaging" R2's groin/vaginal area.

Findings include:

The facility's "Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure", dated 2022, states, "Purpose: To

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ensure that all of (name of skilled nursing facility) residents are free from abuse, neglect, misappropriation of their property and exploitation. Policy: The facility's residents have the right to be free from abuse, neglect, misappropriation of their property and exploitation as defined in this policy." "Procedure: III. The Facility shall review altercations from resident to resident as a potential situation of abuse. A. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to: c. Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing."

The facility's "Elder Justice Act and Reporting Suspected Crimes Against Residents Policy and Procedure", dated 2022, states, "To facilitate efforts to prevent, detect, treat, intervene in and prosecute elder abuse, neglect and exploitation and to protect elders with diminished capacity while maximizing their autonomy and their right to be free of abuse, neglect and exploitation." I. Definitions: C. Abuse. a. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. c. Instances of abuse of all residents, irrespective of any mental or physical condition, that cause physical harm, pain or mental anguish. This includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. i. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual mist have intended to inflict injury or harm. ii. Sexual abuse is non-consensual sexual contact of any type with a resident." "There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or

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incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident." "k. Abuse includes unwanted sexual contact, which includes but is not limited to: 1. Unwanted touching of the breasts or perineal area; 2. A resident who fondles or touches a person's sexual organs and the resident being touched indicates the touching is unwanted through verbal and non-verbal cues; 3. Sexual activities where one resident indicates that the activity is unwanted through verbal and non-verbal cues 4. Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown; 8. Other unwanted actions for the purpose of sexual arousal or sexual gratification resulting in degradation or humiliation of another resident."

R1's Facesheet documents R1 admitted to the facility on 11/4/22 with a diagnosis to include but limited to: Alzheimer's Disease.

R1's Minimum Data Set/MDS Assessment, dated 11/10/22, documents: R1 with moderate cognitive impairment; R1 requires supervision of one person physical assist to ambulate throughout the facility; R1 uses a walker to ambulate; and R1 is not steady with ambulation but is able to stabilize without staff assistance.

R1's "Order Recap Report" for the dates 11/4/22-3/29/23, documents orders for: Aripiprazole Tablet Five mg/milligram, Give 0.5 (half) tablet by mouth one time a day for sexual drive for seven days with an order start date of 12/23/22 and a discontinue date of 12/31/23; Aripiprazole Tablet Five mg/milligram, Give 0.5 (half) tablet by mouth one time a day for sexual

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behaviors with an order start date of 1/20/23 and an order end date of 3/3/23; Escitalopram Oxalate Tablet 10 (ten) mg Give one tablet by mouth one time a day for Depression; sexual urges with an order start date of 3/3/23 and a discontinue date of 3/10/23; and Escitalopram Oxalate Tablet 20 MG Give one tablet by mouth one time a day for sexual urges with an order start date of 3/11/23 and no end date.

R1's Care Plan documents the following: Focused area with an initiation date of 12/23/22 that R1 has an alteration in R1's behavior status related to Alzheimer's, Impaired memory/thinking and Increased sexual drive; R1 may exhibit behaviors such as: increased confusion, making inappropriate comments or physically attempting to touch staff, hospice staff, residents; R1 may be unable to comprehend or remember appropriate behavior due to R1's diagnoses; R1 gets agitated at times with staff and other residents; a goal that R1 will not engage in inappropriate sexual behavior; Interventions are documented as "My (R1's) behaviors will be monitored every shift and documented" with an initiation date of 12/23/22; Intervene as Necessary to protect safety of others; R1 has expressed sexual desires with an initiation date of 12/26/22 and documents interventions as Intervene when risk, resident safety, or the safety of others is involved; Lexapro per MAR (Medication Administration Record) to control sexual urges with a revision date of 3/10/23; and R1 is on Psychotropic Medications due to R1's sexual urges; R1's medication was increased on 3/10/23 for an "unusual occurrence" on 3/7/23.

R1's Nursing Progress Note, dated 2/12/2023 at 3:00 PM, states, "Sitting out here across from desk. Other resident (unknown) out here as well.

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He (R1) pulled penis out and started masturbating. Resident (R1) was directed to stop and could do this behavior in his room."

R1's Nursing Progress Note on 1/9/23 at 1:54 PM documents a new order for Abilify 2.5 milligrams by mouth was received for "sexual behaviors" from V15 (R1's Hospice Physician).

On 3/28/23 and 3/29/23, R1's room was located in the middle of the 400 resident hallway. R7's (female) room was at the end of the 400 hallway and R8's (female) room was directly across the hallway from R1's room.

On 4/11/23 at 1:35 PM and 4/12/23 at 2:35 PM, R1 was observed in R1's room. R1's room was located at the very end of the 400 resident hallway, immediately before the outside exit door and furthest from the Nurse's Station. R7's (female) room was located directly across the hall from R1's room.

1. R4's Facesheet documents R4 admitted to the facility on 5/16/22 with a diagnosis of Schizophrenia.

R4's Care Plan documents the following: R4 is at high risk for Wandering/Elopement; safety will be monitored every shift by all staff; history of wandering, refusal of cares, insomnia, disorganized speech or behavior, difficulty with concentration, compulsive, slowness in activity, delusions, hallucinations; impaired safety awareness and will get close to other residents; and alteration to cognition.

R4's Minimum Data Set/MDS Assessment, dated 10/18/22, contains a Brief Interview of Mental Status which documents R4 with severe cognitive

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S9999	Continued From page 6 impairment. On 3/28/23 at 10:29 AM, R4 was observed wandering aimlessly around the facility's Memory Care Unit. R4 was unable to answer questions due to R4's mental status. The facility's "Serious Injury Incident Report", dated 12/23/22, documents this report as an initial and final report that on 12/23/22 at 11:15 AM, R1 and R4 were in a resident to resident altercation. This same report documents R1 as the "perpetrator", R4 as the "victim" and V8/CNA/Certified Nursing Assistant as a "witness". This report states, "(V8) alerted (V2/Director of Nursing) that (R1) appeared to have his hand in (R4's) sweatpants. (R1) was sitting at his table in the dining room and (R4) was standing in front of (R1). (V8) separated (R1 and R4) immediately and notified (V2)." R1's Nursing Progress Note on 12/23/2022 at 12:31 PM, states, "Hospice/POA/Power Of Attorney/MD/Medical Doctor notified of (R1's) sexual drive change. (R1) monitored in room at this time. Confusion noted. New order received for Abilify x (times) one week to control sexual drive." R1's Nursing Progress Note on 12/23/22 at 12:26 PM documents R1's room was moved "due to inappropriate behaviors." V8's written statement, dated 12/23/22, states, "I went to do personal cares on an (unknown) resident in their room. I had (R4) sitting in a chair in TV/Television Room. (R1) was in the dining room. When I came out of the (unknown) resident's room, I heard (R4) saying, 'No Daddy, No Daddy.' When I got to the dining room, (R1)	S9999		

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was in his chair still. (R4) was standing in front of (R1) and (R1) had his hand down in (R4's) sweatpants. I said, '(R1) stop. Go to your room.' I took (R4) to the TV room and called (V2) immediately."

R1's MDS/Minimum Data Set/Care Plan Note on 12/23/22 at 11:15 AM, states, "Root Cause: (R4 and R1) both have impaired memory, safety awareness, and impaired decision making capability. Intervention: Separated immediately. (R1 and R4) assessed. New order for (R1) to start Abilify times one week trial for sexual drive/behavioral change. (R1) given more privacy and relocated (off of Memory Care Unit). Continue to monitor behaviors and location as able."

On 3/28/23 at 12:10 PM, V8 stated that on 12/23/22, V8 walked out of an (unknown) residents room after providing cares and noticed that R1 had R1's hand "at least up to the wrist" down inside the front of R4's sweatpants. V8 stated it was unknown if R1 was inside R4's incontinence brief/underwear or not. V8 stated, "I heard (R4) saying, 'No daddy. No daddy, stop. Daddy stop.' V8 stated that R4 is confused and wanders throughout the memory care unit. V8 stated that since R1 had admitted to the facility, R1 was having increased behaviors of masturbating. V8 stated that while V8 was providing cares in the unknown resident's room, no other staff members were present on the Memory Care Unit providing supervision of the residents, including R1 and R4.

2. R2's Facesheet documents R2 admitted to the facility on 5/30/2018 with diagnoses to include but not limited to: Severe Vascular Dementia; Disorientation; and Wheelchair Dependency.

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S9999	Continued From page 8 R2's Minimum Data Set/MDS Assessment, dated 2/3/23, contains a Brief Interview of Mental Status which documents R2 with severe cognitive impairment. R2's Care Plan documents R2 is at risk for behavior symptoms related to Dementia; is difficult to redirect at times of behaviors; Attempts to assist other resident's with cares and difficult to educate and redirect due to cognitive impairment. R1's "Nursing Progress Note" on 3/7/2023 at 10:15 PM, states, "(R1) was inappropriately groping another resident (R2). Both residents (R1 and R2) separated and (R1) brought down the hall to be observed by staff." R2's "Nursing Progress Note" on 3/7/2023 at 10:23 PM, states, " (R2) unaware of unusual occurrence. Unable to recall or describe. (R2) had sling positioned in chair, ready to be transferred into bed for evening. Brief, long pants intact." The facility's "Serious Injury Incident Report", dated 3/8/23, documents a "final" report that the "Perpetrator"/R1 and the "Victim"/R2 were in a resident to resident altercation on 3/7/23 at 10:25 PM. V5 (Certified Nursing Assistant/CNA) and V6 (CNA) are documented witnesses. This report states, "(R1) had inappropriate behavior with (R2) by the nurse's station. (R1 and R2) were separated immediately." "Final: (V5) notified (V4/Licensed Practical Nurse) that (R1) appeared to have his hand grabbing/groping (R2's) lap. (V5 and V6) separated immediately. Assessment was performed by (V4)." V5's written statement, dated 3/7/23, states, "I	S9999		

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(V5) was at the nurse's station charting before dinner was served. I looked over and noticed (R2) sitting still next to (R1). I sat up to see what they were doing and I noticed (R1) had his hand on (R2's) vaginal area over (R2's) pants massaging the area. Once I realized what was happening between them, I stood up and removed (R2) from the area, while my co-worker (V6) started to remove (R1). Once (R2) was out of the area, (V5 and V6) told (R1) that behavior was inappropriate and moved him away from other female residents and had him sit in the hallway to eat dinner. Both (V5 and V6) informed our nurse (V4)."

V6's written statement, (undated) but has an electronic stamp 3/9/23, states, "Last night (3/7/23) I was sitting at the desk charting, when the incident happened. I could not see it happen. Another CNA (V5) seen it. We approached (R1) and said, 'We don't do that, keep your hands to yourself, please.' (R1) was laughing in response and said 'ok'. (R1) was taken down the hall to his room. (R1) finished supper and was (assisted) into bed."

V4's written statement (undated) states, "The CNA (V5) came and got me and told me that (R1) had his hands in (R2's) lap grabbing her. We brought the resident (R1) down the hall closer to staff to be monitored."

On 3/28/23 at 10:41 PM per telephone interview due to third shift hours, V4 stated that V5 had reported to V4 that R1 was being "inappropriate" with R2 and R1 had touched R2 near R2's vaginal area. V4 stated that R1 was known to masturbate publicly throughout the facility.

R1's Nursing Progress Note on 3/10/23 at 1:44 PM, states, "Verbal consent received for increase

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in dose of Lexapro to treat sexual urges/behavioral issues. Continue to monitor behaviors."

V14's (R1's Nurse Practitioner) Progress Note, dated 3/14/23, states, "(R1) was having sexual behaviors and masturbating in public. (R1) has also had some inappropriate behaviors toward other residents. Two weeks ago, I changed (R1) from Abilify to Lexapro. Then two weeks later (R1) was increased from 10 milligrams/mg to 20 mg daily."

On 3/29/23 at 3:27 PM, V5 (Certified Nursing Assistant) stated, "(On 3/7/23) I was sitting at the Nurse's desk. We keep a balloon on (R2's) wheelchair to help keep track of (R2) because (R2) is so mobile. I noticed (R2's) balloon was not moving which was not normal for (R2), so I sat up to see what (R2) was doing. That's when I noticed that (R1) had his hands in (R2's) pubic region and was massaging the area. We immediately separated the residents and I reported it to my nurse right away. I don't like to think about that happening to (R2)."

On 3/28/23 at 11:03 AM, V1 (Administrator) stated that R1 "all of a sudden" started masturbating in random places throughout the facility not long after R1 admitted to the facility. V1 stated that R1 has inappropriately touched two residents; R1 had put R1's hand down the front of R4's pants and R1 touched R2's lap area.

On 3/28/23 at 11:12 AM, V2 (Director of Nursing) stated that on 3/8/23, around 9:00 or 10:00 in the morning, V2 was reviewing progress note charting from the night before (3/7/23). V2 stated that V2 found a note charted by V4, that R1 had inappropriately groped R2. V2 stated that V2

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discussed the incident with the staff members who confirmed the incident. V2 stated that R1 had inappropriately touched another resident (R4) "one other time" when R1 touched R4's "private area" back in December 2022 when R1 was a resident on the Memory Care Unit. V2 stated that R1 was placed on psychotropic medications to help manage R1's sexual urges.

As of 4/12/23, R1's medical record did not contain any behavior tracking logs for November 2022 or December 2022.

R1's behavior tracking log for January 2023 states, "Problem: (R1) has a diagnosis of Alzheimer's Disease and increased sexual drive and may exhibit behaviors such as: Physical: Attempting to inappropriately touch staff, hospice staff and residents. Has doubled up fists when agitated at staff and residents. Interventions: 1. Remove resident/R1 from area and put in a quiet area, back to his room, draw curtain. 2. Offer tasks to distract resident from current thoughts, give an activity, snack, or go for a walk." This same form is blank on the dates 1/1/23-1/25/23. On 1/26/23, it is documented a behavior occurred one time.

R1's behavior tracking log for February 2023 states, "Problem: (R1) has a diagnosis of Alzheimer's Disease and increased sexual drive and may exhibit behaviors such as: Physical: Attempting to inappropriately touch staff, hospice staff and residents. Has doubled up fists when agitated at staff and residents. Interventions: 1. Remove resident/R1 from area and put in a quiet area, back to his room, draw curtain. 2. Offer tasks to distract resident from current thoughts, give an activity, snack, or go for a walk. This same form documents behaviors occurred on the

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(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		

following dates either "all" or "half the shift": 2/1/23; 2/2/23; 2/4/23-2/6/23; 2/7/23; 2/9/23; and 2/14/23-2/20/23. The following dates are documented that interventions were not effective: 2/1/23; 2/2/23; 2/9/23; and 2/14/23 and 2/15/23. The following dates are documented that interventions were effective and then R1 reverted back to the same behavior: 2/4/23-2/7/23; 2/16/23-2/20/23. No new or updated interventions are documented as being attempted or implemented.

R1's behavior tracking log for March 2023 states, "Problem: (R1) has a diagnosis of Alzheimer's Disease and increased sexual drive and may exhibit behaviors such as: Physical: Attempting to inappropriately touch staff, hospice staff and residents. Has doubled up fists when agitated at staff and residents. Interventions: 1. Remove resident/R1 from area and put in a quiet area, back to his room, draw curtain. 2. Offer tasks to distract resident from current thoughts, give an activity, snack, or go for a walk. This same form documents behaviors occurred on the following dates: 3/1/23-3/5/23 four times and 3/6/23 three times with interventions documented as not being effective. No new/different interventions are documented as being attempted or implemented.

R1's behavior tracking log for April 2023 states, "Problem: (R1) has a diagnosis of Alzheimer's Disease and increased sexual drive and may exhibit behaviors such as: Physical: Attempting to inappropriately touch staff, hospice staff and residents. Has doubled up fists when agitated at staff and residents. Interventions: 1. Remove resident/R1 from area and put in a quiet area, back to his room, draw curtain. 2. Offer tasks to distract resident from current thoughts, give an activity, snack, or go for a walk. This same form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011613	A. BUILDING: _____ B. WING _____	C 04/25/2023

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S9999	Continued From page 13 does not document monitoring of R1's behaviors on 4/6/23-4/10/23, as these areas are blank. R1's "Social Service Behavior Summary" dated 2/12/23 at 12:23 PM, states, "SSD/Social Service Director (V16) gathered January's behavior charting. (R1 displayed physical behaviors throughout the month randomly, charting was rarely completed. SSD will continue to follow. In-services were completed and charting should be completed better for this month." R1's "Social Service Behavior Summary" dated 3/6/23 at 12:02 PM, states, "SSD gathered February's behavior charting. (R1) displayed physical behaviors half the month with interventions working half the time. Verbal behaviors were displayed a couple days with interventions working. SSD will continue to follow." R1's "Social Service Behavior Summary" dated 4/6/23 at 10:44 AM, states, "SSD gathered March's behavior charting. (R1) did display physical behaviors with interventions working occasionally, verbal behaviors were displayed the same as well as the interventions. Interventions generally revert back d/t (due to) his Dementia. SSD will follow." On 4/12/23 at 3:30 PM, V2 (Director of Nursing) verified no behavior tracking logs for R1 could be provided for November 2022 or December 2022. V2 verified the first behavior tracking for R1 was initiated on 1/26/23. V2 verified no documentation could be provided to indicate increased monitoring or supervision such as 15 minute checks being initiated for R1 after R1's 12/23/22 or 3/7/23 incidents.	S9999		

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 14 On 4/12/23 at 8:51 AM, V2 stated, "I would have expected 15 minute checks to have been implemented for (R1) for at least 24 hours after R1's (12/23/22 and 3/7/23) incidents. It's hard to check on someone every 15 minutes especially when it gets very busy. I feel like being on 15 minute checks too long, the staff gets desensitized to them." As of 4/12/23, R1's medical record did not document 15 minute checks or other increased monitoring was ever completed for R1 after R1's 12/23/22 or 3/7/23 resident to resident incidents. (B)	S9999		