STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001044	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON CARE CENTER	1201 NORTH ALTON LEBANON, IL 62254

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S 000	Initial Comments Complaint Investigation: 2349108/IL166176	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.3210 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 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,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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) 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 3 residents (R2 and R3) reviewed for abuse in a sample of 7. This failure resulted in harm as a reasonable person would not engage in sexual encounters without the decisional capacity to do so. Findings include: 1.) R2's Physician Order Sheet, (POS), dated October 2023 document, a diagnosis of cerebral atherosclerosis, vascular dementia with other behavioral disturbances, hypertension, Alzheimer late onset, major depression, and severe with psychotic symptoms. R2 was also taking Quetiapine fumarate 25 mg once daily in the afternoon and two 50 mg tablets by mouth of Quetiapine at bedtime. Quetiapine is an Antipsychotic medication. R2's baseline Care Plan dated, 8/28/2023 document, R2 is alert to self, for bed mobility she is dependent, with locomotion walks with walker, toileting she is an assist of one and uses pull up briefs. For ambulation, she is independent, she has poor safety awareness, wanders, and uses psych medication. R2's Care Plan with a goal of 2/2/2023, documents R2 has impaired cognition as related	S9999		

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S9999	Continued From page 2 to Alzheimer disease/Dementia. R2's Care Plan does not address abuse. R2's Minimum data Set, (MDS) was not available to review, due to the facility's electronic system being hacked. R2's Elopement Assessment dated 8/29/2023, document, R3 is at risk for elopement, has poor decision-making skills, inability to identify safety needs and has severe mental illness. The form also documents "visual checks every 15 minutes." R2 was admitted to the facility on 8/28/2023 and was admitted on Hospice Care. R2 was admitted to the Dementia Lock down unit. On 10/31/2023 at 2:44 PM, V1 (Administrator) stated, "(R2) and (R3) are both on the Dementia Unit, it is a locked unit. They are both severely impaired for decision making. A staff room found (R2) in (R3's) room and she did not have any pants on, (R3) had his genitals in his hand. We put both residents on one on ones and we are monitoring. This is the first time I am aware of any sexual nature between them. They had held hands in the past but that is it." R2's Incident Report with the date of incident of 10/20/2023, at 5:29 PM, documents, "Alleged inappropriate physical contact between residents reported. No injuries reported. Investigation initiated. Final report to follow." R2's Nurse's Notes dated, 10/20/2023 at 5:30 PM, "On 5 PM, this nurse was alerted by aide that resident was in male resident ('s) room with (adult briefs) off and pants off. Resident lying in male resident('s) bed undressed with fully dressed	S9999		

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S9999	Continued From page 3	S9999		

male resident sitting next to her. Both residents immediate separated. Skin assessment performed also, no signs or symptoms of injury, nor redness, no swelling. Resident alert to self with confusion per usual and unable to state incident. Administrator immediately contacted. Also reported to facility management in which incident was further addressed. Resident is currently on one on ones and monitoring. No signs or symptoms of distress or discomfort observed. Care ongoing."

R2's Progress Notes dated, 10/20/2023 at 5:45 PM, "Call placed to family to report incident of resident in another resident's room (male resident) with (adult brief) and pants down. Head to toe assessment completed by this writer and another nurse. No trauma noted. Administration is aware."

On 11/2/2023, at 11:27 AM, V10 (Family of R2) stated, "I was notified on Friday from a Nurse, I think it was (V8 Licensed Practical Nurse/LPN). She told me they had found my mom naked from the waist down with a man, but they could not tell me his name, because of HIPPA. My mom is very confused, when I come to visit her, she thinks I am her mom. She thinks every man she meets is her husband. The Nurse said my mom was beside herself when they found her. When I asked more details and what she meant by 'beside herself' and if she was 'beside herself', because she got caught or because she is upset. The Nurse would only say that she did not feel my mom initiated it. When I called the Administrator the next day, I got an entirely different story. This frustrates me because the Dementia Unit is not that big. This should have never happened. I do not put the blame on the man or my mom, but when you put your mom in a locked Dementia

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S9999	Continued From page 4	S9999		

Unit, you don't expect to get a call telling them your mom is 'beside herself' and staff found her naked from the waist down with another man. The Administrator was trying to tell me they were being supervised and were only left alone for 10 minutes, but that cannot be true, because it takes my mom 20 minutes to get her clothes off. I just felt like (V1) was trying to cover herself and the facility and was not taking any responsibility. V1 told me I could take my mom someplace else. There are not a lot of locked Dementia Units in this area. It was very upsetting to me to say the least. I just am not sure if my mom was taken advantage of and feel like things should have been put in place to protect her so nothing like this could happen to her or any other female resident living in the facility. I came to visit my mom the next day and her dementia is so bad she could not tell me anything and had forgotten all about it."

Statement by V9 (Certified Nursing Assistant/CNA), dated 10/23/2023 documents, "I walked into (R3's) room and (R2) was laying on her back on the bed her pants pulled down. (R3) was standing at the end of the end of the bed fully clothed but, had genitals in his hand. I stated, 'What are you doing here' (R3) replied 'I am not doing anything. I was readjusting myself.' (R2) stated, 'We are just finishing up here.' I immediately notified the Nurse of the situation."

On 11/2/2023 at 4:31 PM, V9 (CNA), stated, "I was getting everyone up and ready in the dining room. That's when I noticed (R2) and (R3) were not there. (R3's) door was closed and I knocked and when I opened the door (R2) was in his bed without any pants on and (R3) had his genitals in his hands. I asked what is going on here and (R2) stated they hadn't finished yet. This is the

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S9999	Continued From page 5	S9999		

first time I have ever seen (R3) do something like this. They normally like to sit together, but I have never seen them hold hands, kiss, or anything like that. (R3) seemed flustered. I immediate went and got the Nurse."

2.) R3's Physician Order Sheet document, he is a 63-year-old male. R3's POS also documents, a diagnosis of Early onset dementia with moderate severity. No other diagnosis was documented for R3.

R3's Nursing Summary dated, 10/12/2023 document, he has aggression and agitation. He is alert and oriented x 3, with moderate impaired decisions. He is verbally and physically abusive and he is on the dementia care unit. He is independent on his activities of daily living, continent of bladder and bowel and walks independently.

R3's Elopement Assessment dated, 8/29/2023 document, R3 was low risk for elopement. The form also document the IDT (Intradisciplinary Team) has reviewed the resident's capabilities, needs and preferences and has determined resident is not at risk of leaving home unattended.

R3's Nurse's Notes dated, 10/20/2023 at 5:35 PM, "At 5 PM this nurse was alerted by aide that resident had female resident in his room with her brief/pants off. When this nurse arrived to his room, he was sitting upright fully dressed with female undressed and lying in his bed. Both resident immediately separated and assessed. Both currently being closely monitored. Incident reported to administrator and management in facility."

R3's Nurse's Notes dated 10/20/2023 at 5:45 PM,

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S9999	Continued From page 6 "Called Power of Attorney about resident having a female resident in room with pants down. Both residents found with their pants down by Certified nursing assistants." On 11/2/2023 at 1:48 PM, V11 (Medical Director) stated, "I am not familiar with the residents at the facility the NP (Nurse Practitioner) might have more insight, because she sees them more than me. As far as a Locked Dementia Unit it is tricky, because sometimes if you take a resident off the unit, then they become an elopement risk, normally I would expect residents on the Locked Dementia Unit to have been an elopement risk and have a dementia diagnosis. The two biggest groups of sexually transmitted diseases are teenagers and the demented elderly patients. I could understand how a family could be upset when there are sexual relationships going on in the nursing home. The key is there any psychological damage from the encounter? It is not always easy to determine this because of the memory issues. We can't always make a generic judgement. The questions we must ask ourselves is how we prevent this and how do we keep this from occurring." On 11/2/2023 at 2:32 PM, V12 (NP) stated, "If a resident is on the locked dementia unit I would not expect them to be able to make appropriate choices and possess reasonable decision-making abilities for life decision. That is usually why they are on the unit because of their inability to make good decisions." On 11/2/2023 at 4:40 PM, V8 (LPN) stated, "I was passing medications and the aid (V9) came and got me and told me (R2) was in (R3's) room and they were both undressed and (R3) was on top of (R2). I immediate came to the room and when I	S9999		

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S9999	Continued From page 7 entered (R2) was laying in the bed and did not have any pants on. (R2) is very confused and sometimes she can't not verbally tell you what is going on. When I entered the room, I asked what happened and (R2) said we were just finishing and then would not say anything else. I separated them and did an assessment on (R2). After the incident she appeared anxious and upset. I remember seeing them earlier in the room with the couch and (R2), (R3) and (R7) were all sitting together on the couch and (R3) was kissing both on the forehead but (R7) got up and walked away. After (R7) left I think (R3) started fixating on (R2). I never saw them together in a sexual nature before that day." The Abuse Prevention Policy with a revision date of 11/28/2016 documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriations of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to required, to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment." "B"	S9999		