

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/02/2023
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NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSG & RHB	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
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Initial Comments

Complaint Investigation.

2398883/IL165886

Facility Reported Incident Investigation

FRI of 9.6.23/IL164468
FRI of 9.8.2/ IL165482
FRI of 9.27.23/IL165515

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S9999

Final Observations

Statement of Licensure Violations:

300.610a)
300.1210b
300.3210l)
300.3240a)

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

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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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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.3210 General</p> <p>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements are not meet as evidence by:</p> <p>Based on interviews and record reviews the facility failed to prevent an incident of staff to resident inappropriate sexual behavior, failed to prevent an incident of resident to resident sexual assault, and failed to prevent an incident of staff to resident verbal abuse. This affected four of four residents (R1, R9, R10 and R5) reviewed for sexual and verbal abuse. This failure resulted in V4 taking advantage of R1 with a diagnosis of major depression and traumatic brain injury by engaging in sexual intercourse with R1. This failure also resulted in R10 being touched and kissed inappropriately by R9.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>1. R1 face sheet denotes diagnosis of bipolar disorder, major depressive disorder, single episode, personal history of traumatic brain injury.</p> <p>Facility final report to the department dated 9.13.23 denotes in-part incident date 9.6.23, description of occurrence: in part an allegation was made by staff that a housekeeper was sexually inappropriate with R1. E1 was immediately sent home pending investigation. Physician notified of allegation. Police notified. Nurse completed body assessment with no injury noted to R1. Investigation complete. Administrator was notified by nurse on 9/6/23, that she (E2) witnessed E1 and R1 engaged in sexual activity inside R1's room. E2 was instructed to send R1 home immediately. E1 left premises without incident. Administrator presented to facility and initiated investigation. R1 was interviewed and stated "E1 was in my (R1) room, and I asked him (E1) to put on a condom. E1 was standing behind me when E2 entered the room and she (E2) saw us". R1 stated that E1 and her (R1) sexual relationship was consensual. Upon interview, E1 denied the allegation, stating "I (E1) was grabbing the garbage in the room. I (E1) was standing behind R1, who was bent over, when E2 entered the room. Nothing was happening." R1 was transported to the hospital for evaluation. R1 declined rape kit and was returned to the facility. Police IR #xx-xxx44. All residents interviewed indicated feeling safe in the facility with no reports of any issues with staff. Occurrence resolution: R1 still resides in the facility. Resident was assessed by her psychologist, MD, and psychiatrist with no concerns. Based on R1's psychologist, R1 has the mental and emotional capacity to grant consent. R1 states she never felt threatened by</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>E1. Wellness checks completed with no changes in mood or behavior, R1 states she feels safe in facility. E1 was terminated for breaking union work rules. Facility staff were in-serviced on following abuse policy and work rules including but not limited to maintaining or attempting to maintain a relationship with a resident that is sexual or romantic in nature. Care plan reviewed.</p> <p>On 10.7.23 at 10:40am R1 observed alert, orient to person, place, time, situation, R1 agreed to speak to surveyor in private setting, R1 said she solicited V4 (housekeeper/ laundry staff) by asking V4 if he had a girlfriend, V4 replied no, R1 said she asked V4 when was the last time he had sex? V4 replied "it's been a long time", R1 said she asked V4 if he wanted to try it, and V4 said "yes." R1 said her and V4 had been having intercourse since July 2023. R1 said when she would see V4 in the facility she would ask V4 if he wanted to have sex, and V4 would say he will be down there (to her room), and sometimes if V4 is in her room for housekeeping reason she would ask and V4 would say he will be back. R1 said her and V4 got caught on 9.6.23. R1 said she put the condom on V4, she stood up and bent over her wheelchair, R1 said she raised her skirt up so that her lower half of her body was exposed so they could have sex. R1 said someone came in the room, and that prompted her to look around her privacy curtain and sit in the wheelchair, and she saw V5 (laundry staff), V5 was dropping off clothes to her roommate. R1 said she said "what" to V5, and V5 said I didn't say anything, and V5 left out the room. R1 said shortly after that the V2 (nurse) came in the room and observed her and V4 in a sexual position. R1 said when V2 came in the room V4 was about to penetrate her. R1 said she was bent over her wheelchair, V4 was standing behind her, her skirt was up over her</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>lower body, and V4 pants was down. R1 said she feels safe in the facility.</p> <p>On 10.7.23 at 2:54pm V5 (laundry/ housekeeping staff) said he was delivering clothing to bed 2 on 9.6.23 and when he entered the room, the privacy curtain was making a waving motion, V5 said he did hear whispering sound, but he could not make out the voice. V5 said R1 peaked her head from around the curtain and simultaneously sitting herself in the wheelchair and pulling down her skirt. V5 said R1 said "what" and he replied, "I didn't say anything". V5 said he left the room and immediately informed V6 that they might want to check on R1. V5 said he saw V4 exit R1's room with a garbage bag. V5 said V4 asked him what did V5 say to him. V5 said he blew V4 off because he doesn't want to get involved. V5 said he was on his break around 6:00pm, sitting in his car when V4 approached him again, and V4 said "V2 pulled the curtain back and assumed we was doing something, but I was just cleaning the room". V5 said he did not engage V4 in any conversation regarding the incident. V5 said he did not see a housekeeper cart in front or near R1's room when V4 came out of R1's room. V5 said the resident rooms are cleaned on the morning shift not the evening shift.</p> <p>On 10.7.23 at 10:57am V2 (Nurse) said she was informed that R1 was in the room having sex and that she might want to check on R1. V2 said when she went to R1's room, she observed R1 bent over on her wheelchair, V4 was standing behind R1, V4 was having intercourse with R1. V2 said R1's lower body was exposed and V4's lower body was exposed. V2 said V4's pants were down below his knees and above his ankles. V2 said she saw V4 in the physical action of having intercourse with R1. V2 said what she</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>saw total caught her off guard and she gasped and said "STOP" and left the room. V2 said she was in disbelief, distraught, V2 said she was not thinking straight. V2 said she should have made V4 leave R1's room right away, V2 said they can't explain her actions, but she did call the Administrator and DON and informed them of her observation. V2 said the Administrator informed her to tell V4 to leave the facility pending an abuse allegation. V2 said she couldn't interact with V4, so she asked V6 to inform V4 that he had to leave the facility pending an abuse allegation.</p> <p>On 10.7.23 at 4:09pm V6 (nurse) said she was informed by V5 (housekeeping) to check on R1. V6 said she immediately informed V2 to check on R1. V6 said V2 did go and check on R1 immediately. V6 said when V2 returned to the nurse station she asked V2 what was wrong and V2 said "it was V4 in R1's room having sex with R1." V6 said she does remember V2 calling V3 (Administrator) and V1 (DON) regarding the matter. V6 said V3 told V2 to send V4 home pending an abuse allegation. V6 said V2 asked her to tell V4 to leave because she was distraught and could not do it. V6 said V4 was outside, coming from the garbage and she informed V4 that he had to go home, and that he must punch out and leave the premises because there is abuse allegation against him. V6 said V4 got his bag and left. V6 said V4 was gone before the police arrived and before the Administrator arrived. V6 said she doesn't know what color garbage bag V4 had dumped. V6 said she only said to V4 that he had to leave the facility, he had to punch out and leave the premises because there was an abuse allegation against him. V6 said she did not say who the resident was, she did not say who witnessed the incident, she did</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>not say who reported the incident of allegation.</p> <p>On 10.7.23 at 12:33pm V4 (housekeeper/laundry staff) said when V2 (nurse) saw him in R4's room he was dumping the garbage in the room, V4 said when V2 saw him in R1's room R1 was getting in the wheelchair, and R1 had bent over, and he was standing right there. V4 said when R1 bent over her lower body was exposed. V4 said the garbage bag was on the floor when V2 came in the room because he had dropped the garbage. V4 was asked why he didn't remove himself when R1 allegedly bent over and exposed her lower body, V4 said R1 is wide when she bent over, and he didn't think about it. V4 said R1 don't wear underwear, that's why she was exposed when she bent over. V4 was asked how he knew R1 don't wear underwear, V4 said "the CNA told him", when asked who the CNA are, V4 said the CNAs be talking, he don't know who said it. V4 was asked why his pants was down if he was emptying garbage from R1's room? V4 denied that his pants were down.</p> <p>On 10.7.23 at 11:04am V3 (Administrator) said she was notified of the incident and she immediate returned to the facility. V3 said she called the police while she was in route to the facility. V3 said she interviewed R1, and R1's statement has been consistent that her and V4 have been in a sexual relationship since July 2023. R1 said V4 was about to penetrate her when V2 came in the room. V3 said V4 has been terminated per the union contract for having sexual relations with a resident. V3 said she substantiated the allegation; she just did not document the "language substantiated". V3 said staff cannot have sexual relations with any residents. V3 said if a resident has the capacity to consent to sexual relationship, they cannot</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>consent to a sexual relationship with a staff member.</p> <p>On 10.8.23 at 1:58pm V1 (Director of Nursing) said V2 called her on 9.6.23, and V2 informed her that she thinks she saw R1 and V4 having sex. V1 said V2 informed her that she saw R1 and V4's lower body exposed. V1 said she informed V2 to go and get V3. V1 said staff and residents cannot have a sexual relationship, it is not ethical, and it is abuse.</p> <p>R1's progress note dated 9.6.23 denotes in-part report of inappropriate behavior was made involving resident and staff member. Resident reports no injuries. Resident reports feelings safe at this time. ADM/DON/NP (Administrator/ Director of Nursing/ Nurse Practitioner) made aware. DON informed resident's emergency contact. Police notified of allegation IR #xx-xxx44. Writer unable to complete skin/body assessment due to resident being sent to hospital for rape kit. Resident transported to Local Hospital for evaluation.</p> <p>V4 employee report dated 9.6.23 denotes in-part employee was notified by charge nurse on 9.6.23 that an allegation of abuse was made against him, and he needed to clock out and leave the building. Message left by Administrator at 734pm to return call. Return call received at 8:09pm. Administrator informed employee via telephone that he was suspended for duration of investigation. Employee denied the allegation of sexual abuse stating he was taking out garbage and was positioned behind resident in an awkward position. Employee report dated 9.12.23 denotes in-part discharged, other misconduct: abuse, maintaining sexual relationship with a resident. Abuse allegation was investigated R/T</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>(related to) sexual abuse of a resident by this employee. Abuse was witnessed by a staff member and resident admitted to having a sexual relationship with this employee (V4 initials noted). Employee was notified via telephone on 9.12.23 by Administrator and with supervisor present that he is terminated.</p> <p>Facility policy titled abuse prevention dated 2/2020 denotes in-part the facility affirms the resident right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property or mistreatment of the residents. In order to do so, the facility has established a resident sensitive and resident secure environment. The purpose of the policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property or mistreatment of the residents. The facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family member or legal guardian, friends, or any other individual. Abuse means any physical or mental injury, sexual assault inflicted upon a resident other than by accidental means. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment, or misappropriation of resident's property will be removed from the residents contact immediately.</p> <p>During this survey the facility video surveillance</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>was not available.</p> <p>2. Facility final report to the department dated 9.15.23 denotes in-part reportable incident occurred 9.8.23 at 10:05 a.m., individual allegedly involved: resident to another resident. Residents involved R9, and R10 name is noted. Description of occurrence R10 notified Administrator that R9 was inappropriate with her (R10) in the hallway around 10:00a.m., on 9/8/23. R9 and R10 remain separated by staff. Family and Physicians of R10 and R9 notified of allegation. Police notified. Nurse completed body assessment with no injury noted to R10. Investigation complete. Upon interview, R10 stated that R9 "kissed my hand and grabbed my breast in the hallway". Upon interview, R9 stated "I don't know why, I (R9) am bipolar". R9 did not deny the allegation. Police arrived to facility, IR#23-xxxxx. Care plan and assessments reviewed and updated for R10. Staff has continued to monitor R10 for changes in mood or behavior. Staff will continue to conduct well-being checks on R10 to ensure she continues to feel safe in the facility. R9 was monitored by staff 1:1 until he was transported to the hospital for psych evaluation. Residents were provided education on the Abuse Prevention Policy and encouraged to report any instances of abuse to the Abuse Coordinator.</p> <p>On 10.24.23 at 12:11pm R10 said a male kissed her hand and them grabbed her breast. R10 said she can't remember the date, but she did report this to the staff.</p> <p>R10 face sheet shows diagnosis of schizoaffective disorder bipolar type, bipolar disorder, major depressive disorder single episode, anxiety disorder due to known physiological condition. R9 witness statement for</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>abuse allegation dated 9.8.23 at 12:23pm conducted by V3 (Administrator) denotes in-part "I was in the hallway by the activity room and the new guy in the wheelchair (R9) kissed my hand, grabbed my breast and told me he wanted to see my pxxxx".</p> <p>R10 progress notes dated 9.8.23 denotes in-part, writer was informed by social services that resident reported inappropriate sexual behavior with co-peer. ADM/DON/NP (Administrator/Director of Nursing/ Nurse Practitioner) and Mother made aware.</p> <p>R9 PASSR dated 9.5.23 denotes in-part diagnosis of schizophrenia, bipolar disorder, inappropriate sexual behavior, aggression. R9 is not available for observation or interview. R9 witness statement for abuse allegation dated 9.8.23 at 12:23pm conducted by V3 (Administrator) denotes in-part "I don't know, I'm bipolar- that causes me to be inappropriate sometimes."</p> <p>The residents' rights for people in the nursing home denotes in-part you must not be abused, neglected, or exploited by anyone, financially, physically, verbally, mentally, or sexually.</p> <p>3. R5's diagnosis include but are not limited to Type 2 Diabetes, Major Depressive Disorder, Substance Abuse, Homicidal Ideations, Post traumatic Stress Disorder, and Insomnia.</p> <p>On 10/24/23 at 11:48AM R12 said in the early morning hours he heard V7, Certified Nursing Assistant (CNA), "dropping the F bomb" towards R5. R12 said it occurred in the hallway. R12 said V7 has been "mildly aggressive" with residents in the past.</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>On 10/24/23 at 1:31PM V8, Registered Nurse, said V7 told me at 4:00AM that she asked R5 to remove like 12 towels from his room. V8 said V7 reported to her that R5 cursed at her. V8 said V7 told me she said to R5 "same to you." V8 said I did not see any of this I was down the hall passing medications.</p> <p>On 10/24/23 at 1:59PM V3, Administrator, said R5 reported to me that in the early morning hours of the weekend V7 came into his room. V3 said R5 said V7 began to take towels out of the room and he told her to get out. V3 said R5 said as V7 got to the door, f--- you to R5. V3 said I interviewed R5, R12, and R13. R13, R5's wife/roommate, said she heard V7 curse at R5 and V7 had a bad attitude since she entered the room. V3 said while interviewing residents in the hall way R12 said he heard an exchange between R5 and V7. V3 said she is not aware of R5 cursing at staff in the past. V3 said she terminated V7 following the investigation.</p> <p>On 10/25/23 at 10:08AM R5 said V7 came in all mad, she didn't want to work and she had to come in and help my wife. R5 said I am independent but R13 needs help. R5 said V7 started saying you have too many towels, I'm taking them. R5 said he tried to tell V7 that they need the towels, but she kept taking them. R5 said he told V7 to leave and as she was walking out of the room she said f--- you. R5 said I got up and she kept walking. I said what? And she kept walking away towards the nurses station. R5 said R12 saw this, I was telling her she can't talk to us that way. I'm reporting you and I'll have your job. R5 said I followed V7 all the way to the nurses' station and the nurse V8 (R5 said V8's name) was there. The nurse was telling me to calm</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2023
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NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSG & RHB	STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457
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S9999	<p>Continued From page 12</p> <p>down, but she didn't say nothing to V7. R5 said I've heard V7 be rude and curse at other residents before.</p> <p>R5's care plan does not indicate a behavior of cursing at staff. R5's progress notes 9/22/23 - 9/27/23 do not include any notes related to R5 having verbal outbursts or cursing at residents.</p> <p>The facility final abuse investigation dated 10/3/23 states R5 reported to Administrator that V7 was verbally inappropriate with R5 on 9/24/23. R5 reported that V7 said f--- you when he asked her to leave his room.</p> <p>The facility abuse prevention policy dated 2/2020 reads the purpose of this policy is to assure that the facility is doing sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents.</p> <p>(B)</p>	S9999		