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
	IL6001283	A. BUILDING: ______ B. WING ______	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF RIVER OAKS	**14500 SOUTH MANISTEE BURNHAM, IL 60633**

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S 000	Initial Comments	S 000		
	Complaint Investigation 23910430/IL167787			
S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610 a)
300.1210 b)
300.3210 t)
300.3240 b)
300.3240 c)

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 care needs of the resident.

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 01/23/24

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S9999	Continued From page 1	S9999		

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
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)
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

Based on interview and record review, the facility failed to follow its abuse policy by not reporting an observed incident of abuse to the Abuse Coordinator immediately, and failed to prevent a resident (R5) from being sexually assaulted by another resident (R6), for one out of three residents reviewed for abuse in a total sample of eight. This failure resulted in V11 (CNA) observing R5 facedown in the bed crying with R5's naked buttocks exposed, and R6 directly behind R5 in a bed, while R6's pants were around R6's knees.

Findings include:

R5 is a 58 year old with the following diagnosis: bipolar disorder, psychosis, cognitive communication deficit, schizophrenia, developmental disorder, and gastrostomy status.

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S9999	Continued From page 2	S9999		

R5's Abuse and Neglect Screening, dated 11/24/23, documents R5 is at minimal risk for abuse due to having a diagnosis of depression and a psychiatric history.

R5's Care Plan, dated 12/20/22, documents R5 reveals a history of suspected abuse or factors that may increase susceptibility to abuse.

R5's Minimum Data Set (MDS), dated 11/24/23, documents a Brief Interview for Mental Status for as 12 (moderate cognitive impairment). Section E of the MDS documents R5 does not have any hallucinations or delusions.

R6 is a 35 year old with the following diagnosis: schizophrenia, bipolar disorder, and depression.

R6's Minimum Data Set (MDS) does not document a Brief Interview for Mental Status score. Section E of the MDS documents R6 experiences delusions.

A Nursing note, dated 12/13/23, documents R5 was assessed for injuries following a reported allegation of inappropriate behavior by another resident. R5 was found to have no apparent injuries. R5 is going to be sent to the hospital for a medical evaluation.

The following documentation is regarding R6 being sent to the hospital on 12/12/23. The nursing notes as well as the behavior assessments document R6 was not on one to one observation until around 5PM on 12/12/23.

The Behavior Assessment, dated 12/12/23 at 10:37 AM, documents R6 is experiencing verbal aggression, hallucinations, and being socially inappropriate. R6 is exhibiting and expressing

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S9999	Continued From page 3	S9999		

delusional and hallucinatory behavior in nature. R6 is hearing voices with increased agitation. The psychiatrist was contacted and R6 was calmed/reassured through words. R6's behavior stopped.

A Nursing note, dated 12/12/23 at 12:43 PM, documents R6 verbalized hearing voices that are causing agitation with aggression. The psych nurse practitioner was made aware and ordered for a PRN injection for increased anxiety.

The Behavior Assessment, dated 12/12/23 at 5:01 PM, documents R6 is experiencing verbal aggression, inappropriate language, hallucinations, and socially inappropriate. R6 is exhibiting auditory hallucinations aggression with increased agitation and using inappropriate profanity. R6 is not easily redirected. The physician and psychiatrist were contacted. Hospitalization is required. A PRN (as needed) psychotropic medication was used

A Nursing note, dated 12/12/23 at 5:04 PM, documents R6 kept exhibiting auditory hallucinations with increase agitation. R6 is not easily redirected. The psych nurse practitioner was notified of the behavior and ordered R6 be sent to the hospital for a psych evaluation. R6 was placed on a one-to-one observation until the arrival of the ambulance.

A Nursing note, dated 12/12/23 at 10:28PM, documents R6 was picked up by the ambulance and transferred to the hospital for a psych evaluation.

An Administrative note, dated 12/13/23, documents it was reported that a peer allegedly demonstrated sexually inappropriate behavior

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S9999	Continued From page 4	S9999		

towards R5. An abuse investigation has been initiated per protocol. R5 was transferred to the hospital.

The Police Report, dated 12/13/23, documents the police officer was dispatched to the facility in reference to a delayed criminal sexual assault. V1 (Administrator) reported receiving a phone call around 4 PM on a landline phone advising that sexual assault had occurred in the facility. V1 reported the caller was anonymous, and was unable to provide a phone number for the call. The two residents named in the allegation were R5 and R6. V1 further endorsed the caller claimed R6 sexually assaulted R5 on 12/12/23. V1 reported speaking with staff members who worked with R5 and R6 on the listed date of the incident. V1 provided the police officer with voluntary written statements from employees. None of the employees were on the scene. V1 endorsed R6 was removed from the facility around 10 PM and sent to the hospital. V1 stated R5 was going to be transported to the hospital for a sexual assault evaluation. The police officer went to the hospital on 12/14/23. The police officer spoke with the nurse at the hospital who stated she was only able to communicate with R5 briefly, and R5 denied being sexually assaulted to the nurse. The nurse reported the evaluation concluded with negative results for any physical evidence of R5 being sexually assaulted. The nurse reported R5 suffers from severe psychosis, and is only able to communicate coherently for short periods of time. The police officer attempted to speak with R5, but had negative results. R5 was observed in the emergency room sitting on the bed in an upright position with knees tucked into his chest, rocking back-and-forth. The police officer attempted to ask R5 common questions, such as R5's name and date of birth. R5 only

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S9999	Continued From page 5	S9999		

responded by making moaning and growling sounds.

The Hospital Records, dated 12/13/23, document R5 was seen in emergency department due to an alleged sexual assault in the nursing home on 12/12/23. A CNA saw R5 allegedly being sexually assaulted, but did not report it to any staff members or to the Director of Nursing. R5 is alert, but has bizarre behavior and is unable to provide any meaningful history. R5 was observed yelling intermittently. R5 was admitted to the hospital due to an elevated lab level and altered mental status. R5 has no physical trauma to the body. A rape kit was performed in the emergency department.

On 12/15/23 at 11:34AM, V11 stated on 12/12/23, V11 began getting residents up for dinner, and upon entering a resident room, V11 saw R5 facedown on a bed, with R5's naked buttocks exposed, and the buttocks lifted off the bed. V11 endorsed R6 was directly behind R5 with R6's pants down around the knees, and R6 was doing a hip thrusting motion towards R5's buttocks. V11 confirmed R5 was crying and yelling, but was not able to understand what R5 was yelling. V11 reported when R6 noticed V11 was in the room, R6 ran out of the room while pulling up R6's pants. V11 stated V11 immediately called V13 (Nurse) and V19 (Nurse) into the room while R5 laid in the bed crying. V11 endorsed V13 and V19 asked R5 what happened, and R5 pointed to R5's buttocks and cried. V11 reported R5 was not able to verbally state what R6 did. V11 denied telling V1 about the abuse. V11 stated V11 told the nurses what the abuse so V11 "thought they would tell" V1. V11 confirmed other staff members kept coming up and asking questions about the incident all night, but no staff called V1.

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S9999	Continued From page 6	S9999		

V11 reported asking V19 if V19 was going to notify V1 about the incident, and V19 stated V19 "wasn't really sure what happened to (R5) and (R5) seemed to be OK now." V11 confirmed R6 was sent to the hospital that evening but was unsure why.

On 12/15/23 at 12:24PM, V13 (Nurse) stated being notified around 4PM that staff needed to monitor R6 as a one to one, due to R6 needing to be sent out to the hospital for a psych evaluation. V13 endorsed R6 was brought down to the first floor to be monitored at some point during the second shift, but V13 could not say when R6 was brought downstairs. V13 reported R5 does have a behavior of wandering into other resident rooms. V13 denied seeing R6 up walking around that evening, but also reported V14 (CNA) was responsible for monitoring R6. V13 denied being notified by V11 or hearing V11 talk about a sexual assault between R5 and R6 that evening. V13 endorsed all abuse should be reported to the Administrator immediately.

On 12/15/23 at 1:33PM, V12 (CNA) stated V12 saw R5 wandering in and out of resident's room around 4:30-5:00PM. V12 endorsed R6 was being monitored near the nurse's station, but did see R6 up walking the halls while V12 was taking residents to the dining room for dinner. V12 denied telling other staff R6 was up walking around, and directed R6 to sit back near the elevator. V12 stated V12 heard V11 talking with staff about seeing R6 "having sex with" R5. V12 confirmed throughout the night "a lot" of staff members were heard talking about the abuse allegation between R5 and R6, but V12 could not remember exactly who the staff members were. V12 denied reporting the allegation to anyone because V12 thought V11 reported the incident.

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S9999	Continued From page 7	S9999		

V12 stated any abuse allegation should be reported to V1 immediately. V12 denied telling any nurses about see R6 up walking around and stated, "We were all busy taking residents to the dining room for dinner, so we couldn't stay there and watch R6 the whole time."

On 12/15/23 at 1:49PM, V14 (CNA) stated V13 told V14 to monitor R6 on a one to one due to needing to be sent out to the hospital. V14 endorsed R6 was put on monitoring "around dinner time", but V14 still had other residents to care for. V14 stated V14 would go take other residents to the dining room and care for them and then come back and check on R6. V14 reported R6 went down to the first floor to be monitored, but was unable to state a timeframe of when. "We were all busy taking residents to the dining room for dinner so we couldn't stay there and watch him the whole time." V14 denied seeing or hearing about any sexual assault between R5 and R6 that shift.

On 12/15/23 at 2:17PM, V15 (Psychiatric Nurse) stated R6 began having auditory hallucinations with agitation on the first shift. V15 was not able to state exactly what the voices were saying, but recalled R6 stating R6 "was hearing something." V15 confirmed calling a Nurse Practitioner, and got an order to give the as needed medication for the hallucinations. V15 reported R6 was still displaying the behaviors after the medication, so the physician ordered to send R6 to the hospital for an evaluation. V15 endorsed speaking with the physician around 4 or 5PM, and at this time R6 was put on one to one monitoring. V15 stated, "A resident who is being monitored one to one should never be left unattended, and needs one staff watching them at all times for safety." V15 denied hearing about any allegation between R5

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S9999	Continued From page 8	S9999		

Continued From page 8

and R6 until 12/13/23. V15 stated that evening, R6 was being aggressive and breaking facility property.

On 12/15/23 at 2:36PM, V16 (Assistant Director of Nursing/ADON) stated R6 was being sent to the hospital on second shift due to having hallucinations. V16 endorsed before R6 was sent to the hospital, R6 was put on one to one monitoring around dinner time. V16 reported since staff was busy with other residents at dinner time, R6 was sent down to the first floor at this time to be monitored by staff downstairs. V16 stated R6 left the facility around 10PM that evening. V16 denied having any reports from staff that day about any abuse between R5 and R6. V16 reported the incident being brought to V16 attention the following day on 12/13/23, when V1 called to tell V16 there was an allegation of R6 "raping" R5. V16 stated staff should report any allegation of abuse to V1 immediately.

On 12/15/23 at 3:19PM, V19 stated being told on 12/12/23 that R6 needed to be monitored due to hallucinations, and was going to be sent to the hospital. V19 reported delegating the monitoring to V14 because V19 was busy helping another resident. V19 endorsed being aware R6 went down to the first floor to be monitored, but was not aware of the time R6 went downstairs. V19 first denied V11 called V19 into a resident room where R5 was, but then admitted V11 did call V19 into a resident room where R5 was for assistance. When asked why V11 called V19 into the resident room, V19 stated "because (R5's) G tube was open and it was leaking." V19 denied having a feeding infusing at the time V19 was called into the room. V19 confirmed R5 was wearing a hospital gown and did not have on any underwear. V19 denied being told about any

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S9999	Continued From page 9	S9999		

abuse between R5 and R6 by V11 or any other staff.

On 12/19/23 at 10:55AM, this surveyor interviewed R5 at the hospital where R5 was admitted on 12/13/23. R5 was alert and oriented times two. R5 was able to state R5's name, but did not know the date or where R5 was at. R5 was able to state R5 was in a hospital, and R5 came to the hospital from a nursing home. R5 was not able to state where the nursing home was located. R5 would answer questions by saying "yes" or "no" or by giving two or three word answers. When asked if R5 felt safe at the facility R5 came from, R5 said "no" and began to cry. When asked why R5 did not feel safe, R5 stated, "He hurt me!" R5 then began to scream and cry thing that were unintelligible. After R5 calmed, R5 was asked to point on R5's body where R5 was hurt, and R5 pointed R5's buttocks. R5 then screamed, "He hurt my butt!" R5 shook head "no" when asked if R5 wanted to return to the facility after the hospitalization. R5 was unable to remember the date the incident occurred. When asked to describe the person that hurt R5, R5 stated "a tall, black man." When asked if R5 told the man to stop hurting R5, R5 shook head "yes." R5 was unable to say if anyone else saw the incident. R5 was unable to give a description of exactly what happened due to a communication deficit.

On 12/19/23 at 1:17PM, V11 was interviewed again to confirm the statement made from the previous interview. V11 stated again R5 was found face down in the bed with a naked buttocks exposed, with R6 directly behind R5 while they were in bed. V11 stated R6's pants were down around R6's knees, and R6's genitals were exposed as R6 ran out of the room once R6 saw

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S9999	Continued From page 10	S9999		

V11. V11 reported telling the nurses what happened immediately after the incident. V11 denied ignoring calls from V1, and reported V11 has given two statements over the phone to V1.

On 12/19/23 at 1:35PM, V1 stated an anonymous person called the facility on 12/13/23, and reported R6 "raped" R5 on 12/12/23. V1 reported the caller confirmed V11 was talking about the incident the day before. V1 denied having any staff report any abuse allegations to V1 on 12/12/23. V1 stated an investigation was initiated, and the police were notified. V1 reported beginning to interview staff members, and all staff denied any incidents or abuse between R5 and R6 on 12/12/23. V1 endorsed the facility has attempted to contact V11 for a statement, but no call has been returned. V1 stated the physician was notified, and R5 was sent to the hospital for an evaluation. V1 denied interviewing R6 due to being at the hospital before the allegation was brought to V1's attention, and denied interview R6 before R6 left for the hospital. V1 stated at the hospital, R5 denied being sexually abused and that it is noted in the police report. V1 stated all staff should report any allegations of abuse immediately to V1, even when V1 in no tin the building.

On 12/19/23 at 2:57PM, V18 (Medical Director) stated V18 is "not very happy" with the staff at the facility due to the delaying of reporting allegation of abuse between R5 and R6. V18 endorsed this incident should have been brought to the nurse's attention immediately. V18 reported assessing R5 while at the hospital, and did not see any physical signs of abuse, and R5 denied being touched while in the emergency room. V18 stated, "If staff did not want to report it, then the person who saw it should have called the Administrator to let them

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S9999	Continued From page 11	S9999		

know what happened." When asked to define rape versus assault, V18 stated, "Assault and rape are different. Rape would be actual penetration where assault can be pretty much anything. It can be an attempt at rape or it could be something as simple as unwanted touching. Assault is a very broad term in regards to an allegation. All forms of assault mean it was unwanted." V18 confirmed assault would still be considered abuse.

On 12/19/23 at 6:02PM, V20 (Detective) stated V20 was notified of the allegation on 12/13/23, and went to the facility to begin the investigation. V20 reported seeing R5 at the hospital on 12/14/23, but R5 was in a psychotic state and was not able to be interviewed. V20 confirmed hospital staff stated R5 denied being abuse, but V20 was not able to personally ask R5 these questions due to R5's mental state.

On 12/21/23 at 10:42AM, R6's orientation was checked with basic questioning. R6 was able to state R6's name and reported the dated as December of 2022. R6 was not able to state the day or the day of the week. R6 did know R6 was currently in a nursing home in (city). R6 was not able to state how long R6 has been a resident at the facility, but endorsed "it hasn't been too long." When asked where R6 was the previous week, R6 replied, "the hospital." When asked why R6 was at the hospital, R6 stated, "I broke some TVs and wasn't being good here." R6 was unable to recall why R6 broke the TVs or what lead up to R6 being sent to the hospital. When asked what happened at the hospital, R6 stated, "The nurse told me I was being sexually inappropriate and was touching people." R6 was not able to say who R6 was touching or how R6 was touching people. When asked how R6 was sexually

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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		

inappropriate at the facility, R6 stated, "I don't know. I was just touching people before I left." When asked who told R6 that R6 was being sexually inappropriate, R6 replied, "A nurse at the hospital told me." R6 then abruptly ended the interview by walking out of the room to the nurse's station. R6 refused to answer any further questions.

The Abuse policy, dated 9/30/2023, documents, "This facility affirms, the right of a resident to be free from abuse, neglect, exploitation, appropriation of property or mistreatment. This facility, therefore prohibits abuse, neglect, exploitation, appropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents This will be done by: ... orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse ... This facility is committed to protecting a resident 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 members, or legal guardians, friends, or any other individuals ... Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident, other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001283	A. BUILDING: ______ B. WING ______	C 01/09/2024

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S9999	Continued From page 13	S9999		

mental anguish to a resident ... The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ... Sexual abuse includes but not limited to, sexual harassment, sexual corrosion, or sexual assault."

(A)