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
	IL6007090	A. BUILDING: ______ B. WING ______	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARIS HEALTH AND REHAB CENTER	**1011 NORTH MAIN STREET PARIS, IL 61944**

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S 000	Initial Comments Complaint Investigation: 2460162/IL168468 A Partial Extended Survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/24

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resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to prevent staff to resident mental abuse and failed to immediately suspend alleged perpetrators in order to prevent further staff to resident mental abuse. This failure affects three of four residents (R2, R3, R4) reviewed for abuse. This failure resulted in R2, R3, and R4 being subjected to mental abuse by two Certified Nurses Assistants (CNAs) (V9, V14) engaging in sexual behavior in residents' rooms.

Findings Include:

1. On 1/7/24 at 1:00 PM V11 Certified Nurse's Assistant (CNA) stated on 12/15/23 at approximately 9:20 AM V11 observed V14 CNA standing right behind V9 CNA, rubbing on V9's bottom when V9 was assisting R4 with a shower. V11 is unsure if R4 understood what was going on but V11 stated R4 could see both V9 and V14. V11 stated she did not report this to V1 Administrator.

R4's Medical Diagnoses List dated January 2024 documents R4 is diagnosed with Intellectual Disabilities, Alzheimer's Disease, Psychosis, and Parkinson's Disease.

R4's Minimum Data Set (MDS) dated 12/13/23

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documents R4 is cognitively intact however when interviewed R4 was not answering questions appropriately and appeared confused. R4's same MDS documents R4 requires maximum staff assistance for showering.

R4's Care Plan dated 10/26/23 documents R4 is at risk for abuse/neglect do to vulnerable physical condition.

2. On 1/7/24 at 11:06 AM V4 Registered Nurse (RN) stated on 1/2/24, V5 CNA and V11 CNA called her to R3's room. R3 reported to V4 that two female CNAs had been kissing in his room and doing sexual things in front of him on three different occasions. V4 stated R3 appeared very upset and uncomfortable with the situation. V4 stated she immediately reported R3's allegations to V1 Administrator. V4 stated V1 told her the situation was being handled, she shouldn't believe rumors and asked V4 to talk to R3 and encourage him to not discuss it further with anyone. V4 stated she was never interviewed and never asked to make a statement regarding R3's allegations.

On 1/9/24 at 11:30 AM R3 stated two girl Certified Nurses Assistants (CNAs) (V9, V14) came into his room to care for him. Three times last week, they kissed each other in front of him. Twice they went into the bathroom. Once with the door closed. R3 stated he could not see but could hear what he described as loud sexual noises. R3 stated they went into the bathroom a second time with the door open and R3 could see the one of them push the other one against the wall and get down to her knees with her head in the others pelvis. R3 stated there was a lot of sexual noises and moaning. (R3 started tearing up) R3 stated he hates to talk about it. It makes him so

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uncomfortable. He does not want to see other people engaging in sexual/intimate things in front of him. R3 stated nobody wants to see that kind of stuff. R3 stated those things should be done in private. R3 stated he told some other staff (CNAs) (V5, V11) and his nurse (V4 Registered Nurse) and his daughter (V17).

R3's Medical Diagnoses List dated January 2024 documents R3 is diagnosed with Pubis Fracture, Heart Failure, Cancer History, and Skin Infection.

R3's Minimum Data Set dated 12/12/23 documents R3 is cognitively intact. R3 has a history of a Stroke and requires staff assistance for toileting, transferring, bed mobility, and personal hygiene.

R3's Care Plan dated 12/18/23 documents R3 is at risk for abuse/neglect do to vulnerable physical condition.

3. On 1/7/24 at 12:14 PM V12 CNA stated on 1/4/24 she witnessed V9 CNA and V14 CNA making out in R2's personal bathroom while R2 sat on the edge of his bed. The bathroom door was open and R2 was approximately ten feet away. V12 stated she immediately reported this to V1 Administrator. V12 stated she made V1 Administrator aware that V9 and V14 were scheduled together again the following day (1/5/24). V12 stated she was never asked for a statement or interview regarding an investigation. V12 stated both V9 and V14 did work together again the next day - 1/5/24.

R2's Medical Diagnoses List dated January 2024 documents R2 is diagnosed with Alzheimer's Disease, Mood Disorder, Post-Traumatic Stress Disorder, and Anxiety.

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R2's Minimum Data Set (MDS) dated 11/22/23 documents R2 is severely cognitively impaired. R2's same MDS documents R2 requires staff assistance for toileting, transferring, bed mobility, and personal hygiene.

R2's Care Plan dated 12/8/23 documents R2 is at risk for abuse/neglect do to vulnerable physical and mental condition.

On 1/7/24 at 2:40 PM V1 Administrator confirmed the 12/15/23 allegation was never reported to her. V1 Administrator confirmed both the 1/2/24 and 1/4/24 allegations were reported to her however she did not identify potential abuse and did not complete an abuse investigation regarding either incident. V1 confirmed both V9 CNA and V14 CNA were not suspended until the afternoon of 1/7/24 after the state survey agency investigation already began. V1 confirmed sexual interactions between staff members while at work was inappropriate and not acceptable.

On 1/7/24 at 5:15 PM V2 Director of Nurses confirmed both alleged perpetrators (V9 and V14) were allowed to continue to work after allegations were reported and worked shifts on 1/2/24, 1/3/24, 1/4/24, 1/5/24, and 1/7/24. V9 CNA was working on 1/7/24 when this survey began. V2 Director of Nurses confirmed both V9 and V14 had access to all residents in the facility when they worked.

On 1/10/24 at 2:39 PM V3 Regional Consultant confirmed sexual interactions between staff are not appropriate while in the facility and if done in front of a resident, the action could be considered mental abuse. V3 confirmed the expectation is for staff, including V1 Administrator, to follow the

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facility abuse policy by thoroughly investigating all allegations of potential abuse, suspending alleged perpetrators, and reporting alleged abuse to required entities in the correct timeframe.

On 1/5/24 both V9 CNA and V14 CNA were given Written Corrective Action for the incident on 1/4/24. Corrective Action form documents this was their second warning of inappropriate behavior, sexual in nature, in the workplace. A verbal and written warning were given for prior inappropriate sexual behavior in the workplace for an incident that occurred on 12/18/23 where V9 and V14 were observed kissing in a residents (R1's) bathroom. R1 was not present at the time. These details were confirmed by V1 Administrator on 1/10/24 at 2:09 PM.

The facility's Abuse Policy date 9/15/23 documents the purpose of the policy is to provide guidance and procedures to the facility and staff to assure residents remain free from abuse. The policy documents the facility is to designate an Abuse Coordinator and all staff are responsible to report any allegation or witnessed abuse immediately to the Abuse Coordinator (Administrator). The facility is to do everything within it's control to prevent occurrences of abuse. Part of this process is to establish an environment that promotes resident sensitivity, resident security, and prevention of mistreatment; immediately protecting residents involved in identified reports of possible abuse; implementing systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment and make necessary changes to prevent future occurrences; as well as filing accurate and timely investigative reports.
The policy documents any staff member or person suspected of abuse will be escorted by

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S9999	Continued From page 6 staff out of the facility and will not be permitted back in the facility until the investigation has completed. The facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities, including the State Surveying Agency, Ombudsman, Resident's Power of Attorney, and Physician. The facility will immediately and thoroughly investigate all allegations of abuse to include but not limited to interviews with residents, staff, visitors, and vendors. The policy defines Abuse as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is a willful act that causes physical harm, pain, or mental anguish. 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. (B)	S9999		