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S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.610a) 300.1210b) 300.3240a) 300.3240c) 300.3240f) 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	S9999	Attachment A Statement of Licensure Violation	

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care and personal care shall be provided to each 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. (A, B) (Section 2-107 of the Act)

Section 300.3240 Abuse and Neglect

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. (Section 3-610 of the Act)

f) Resident as perpetrator of abuse. 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 are not met as evidenced

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by:

Based on interview and record review the facility failed to protect residents from unwanted sexual advances that include sexually inappropriate touching and making sexually inappropriate comments towards 3 of 4 residents (R6, R7, and R8) reviewed for abuse in the sample of 20. This failure resulted in R6, R7, and R8 being very upset, anxious, fearful, and becoming increasingly afraid.

The Findings include:

R1 was admitted to the facility on April 12, 2018 with a diagnoses of mood affective disorder, dementia without behavioral disturbance, dementia with behavioral disturbance and metabolic encephalopathy. R1 was discharged from the facility on August 5, 2018.

On August 14, 2018 at 10:00 AM, R13 who was the roommate to R1 at admission said R1 was rude and had no respect for anyone else. R13 said R1 would yell and cuss at him and he felt like he had done something wrong.

On August 15, 2018 at 1:15 PM, R11 and R12 who are roommates and across the hall from R1's first room in the facility said R1 would sit in their doorway and stare at them. R11 and R12 said it made them feel scared and very uncomfortable. R11 and R12 said they did tell some staff about it. R11 and R12 both said they are glad R1 is gone.

On August 14, 2018 at 9:50 AM, V13 LPN and V16 LPN said R1 was rude and demanding to

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staff and residents, would make inappropriate sexual comments to residents and have inappropriate touching to female residents. V16 said R1 would be placed on 15 minute checks for better supervision but no staff were assigned to do this, "we just keep an eye on him".

On August 14, 2018 at 9:55 AM, V19 CNA said R1 would cuss at the staff and residents when he did not get his way and make inappropriate comments to the other residents. "We were told to keep an eye on him". V19 said she was not aware he was on 15 minute checks.

On August 14, 2018, at 9:56 AM V18 CNA said R1 would make sexual remarks to staff and residents. V18 said there was no direct order to supervise any closer.

On August 14, 2018 at 9:20 AM, V17 CNA said R1 would get agitated with the other residents if he did not get his way. R1 would make sexual comments to the staff and residents. V17 said they were told to just keep an eye on him.

On August 14, 2018 at 3:15 PM, V3 Social worker said R1 was sexually inappropriate with the other residents almost immediately after being admitted to the facility.

The facility provided the abuse allegations dated January 1, 2018 to August 14, 2018 which includes: R1initiated 4/26/18 to R8, 5/5/18 to R7 and 8/5/18 to R6.

On August 14, 2018 at 11:05 AM, R8 said R1 touched her breast as they were going into the dining room. R8 said R1 was behind her and asked where she was going. R8 said the next thing she knew his hand was on her breast. R8

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said she went right away to a staff person at the front desk and said what happened. R8 said this made her very upset and was glad the facility moved him to another dining room so she did not have to see him in there anymore. R8 also said when she went to talk to the nurse about R1, she was told he was confused and R8 felt like no one really cared about the trouble R1 was causing. R8 said she is glad R1 is gone now from the facility.

On August 15, 2018 at 2:20 PM, V1 Administrator said she would consider getting the breast touched sexual abuse. V1 said she spoke with both R1 and R8 after the incident and she believed R1's story that the incident was an accident.

The MDS (Minimum Data Set Assessment) for R1 dated April 23, 2018 shows he has severe cognitive impairment. The MDS for R8 dated July 13, 2018 shows her to be cognitively intact.

The investigation was labeled "other" rather than sexual assault and only R1 and R8 were interviewed.

On August 14, 2018 at 11:00 AM, R7 said R1 touched her thigh and her breast. R7 said she was headed to her room at the end of the hall and R1 was sitting outside his door which was next to hers. R7 said R1 asked her to "see what you got" then touched her breast and her thigh. R7 said she was afraid of him and went to the nurse's station to report what had happened and just stayed there until R1 was moved to another room. R7 said she is glad he is gone from the facility.

On August 15, 2018 at 2:20 PM, V1 said R1 was moved to another room in the facility after this

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incident. V1 said she does not know why R1 was not sent out for an evaluation after this incident.

The MDS for R7 dated May 25, 2018 shows her to be cognitively intact.

The facility abuse investigation and report shows an interview with R7. No interviews with staff or other residents about the behavior of R1 was documented.

On August 14, 2018 at 1:45 PM, R6 said R1 tried several times to grab her hand and put it on his crotch and would rub her back or shoulders. R6 said R1 was always causing trouble.

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On August 15, 2018 at 1:05 PM, R10 (former resident on same hall as R1) said he was in the dining room and saw R1 roll up behind R6 and rub her back. R10 said he heard R6 say, "I don't like people talking dirty to me". R10 said he told the CNA (Certified Nursing Assistant) later that night about what he had seen. R10 felt it was very inappropriate for R1 to do that.

On August 16, 2018 at 1:05 PM, V21 CNA said R10 told her that he saw R1 rubbing R6's back and heard R6 say she did not like people talking dirty to her. V21 said she went and told the nurse right away.

On August 14, 2018 at 2:00PM, V24 LPN (Licensed Practical Nurse) said she spoke with R6 after hearing of the allegation. V24 said R6 told her about the rubbing and that she would never let a man talk to her that way again. V24 said she told the administrator about the incident the next morning and was told it would be taken care of.

The nursing progress note dated July 23, 2018

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shows R6 telling V24 that R1 took her hand and tried to place it on his genitals. R6 stated she pulled her hand away and did not want to touch it and R1 told her it would feel good.

On August 14, 2018 at 1:50 PM, V22 and V23 (R6's daughters) said they were never notified of this happening.

On August 15, 2018 at 2:20 PM, V1 said she was never given a report of this happening.

There is no abuse investigation into this incident, even after reported to administrator by this surveyor.

On August 14, 2018 at 1:05 PM, R6 said she was sitting at the dining room table when R1 rolled up to her and sat very close to her. R6 said she told R1 to move over and he touched my leg and moved his hand up to her crotch. R6 said she yelled at him and slapped R1 in the face. R6 said she was so mad and just reacted.

The MDS dated July 19, 2018 for R6 shows her to be cognitively intact.

On August 14, 2018 at 9:23 AM, V4 RN (Registered Nurse) said she was the nurse on duty the day R6 and R1 had their altercation. V4 said she had her back to the dining room and did not see what happened but heard a staff member say "what are you doing" very loudly. She turned and saw R6 standing up and yelling "He grabbed my crotch". V4 said R1 was sent to the hospital that day for his behavior. V4 also said if R1 was out of his room she knew to keep an eye on him as he was not always on 15 minute checks.

On August 14, 2018 at 3:15 PM, V3 (Social

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Service) said R1 was transferred to the hospital for a psychiatric evaluation that day because something needed to change with his behavior as he was putting other residents at risk.
On August 15, 2018 at 2:20 PM, V1 said R1 was sent to the hospital that day and not after the previous incidents, because R6 slapped him back and someone could get hurt.

The behavior notes for R1 dated: May 1, 2018, May 4, 2018, May 6, 2018, May 18, 2018, and May 19, 2018 shows R1's continued reports of aggression towards other residents, taking himself into other female resident's rooms while they are dressing, using foul language towards fellow residents and making sexually inappropriate comments to female peers.
The COMS (R) Long Term Care Evaluation dated May 20, 2018 documented by V14 LPN shows, "residents are becoming increasingly scared of him and social services was told that one resident does not want to be near him at all".
On August 16, 2018 at 1:38 PM, V14 said she left a voice mail for the social service department regarding the resident's concerns with R1. V14 said R19 was immobile due to Multiple Sclerosis and was always fearful he would come after her.
On August 16, 2018 at 1:55 PM, R19 said she was afraid of him, "If he blew his cool, I would be a magnet, I can't defend myself". R19 also said she was happy R1 was no longer in the facility.

The facility provided the criminal history background check completed on May 10, 2018 which came back with hits to include aggravated battery. R1 was admitted to the facility on April 12, 2018.

On August 15, 2018 at 3:00 PM, V1 said in her experience background checks are done before a

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S9999	Continued From page 8 resident is admitted to the facility. V1 said she does not ever check them and is unsure what the dates mean. V1 said the facility should know if a resident is an identified offender but she is not the facility. V1 said, "I guess we obviously were not managing him well". The care plan for R1's sexually inappropriate towards peers and staff shows the intervention provide constant supervision when resident is not in room. This intervention was initiated on June 16, 2018 and created on May 31, 2018. A resolved date of August 14, 2018 was present on the care plan but R1 was discharged August 5, 2018. There is no record of a 1 to 1 observation being done. The 15 minute logs for R1 were reviewed and no consistency was shown in when they were completed or why. The facility said they do not have a policy for 1 to 1 observations or 15 minute checks. (B)	S9999		