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
	IL6008650	A. BUILDING: _____ B. WING _____	C 03/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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S 000	Initial Comments Complaint Investigation #1941669/IL110185	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 1) 300.610a) 300.1210b) 300.1220b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 requirements were not met evidencded by:	S9999		

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Based on interview, observation and record review, the facility failed to adequately assess/identify sexual vulnerability and increased risk of resident to resident abuse and failed to implement/monitor interventions and prevent resident to resident abuse for two of three residents (R6 and R7) reviewed for abuse in a sample of 11. This failure resulted in R7 being sexually assaulted by R6.

Findings include:

1. On 3/12/19, throughout the day, R7 was observed to have a 1:1 staff in attendance and was noted to roam independently throughout the facility and in/out of rooms.

R7's Electronic Health Record (EHR) Profile Page documents R7 as being a 72-year-old female admitted to the 300 halls at the facility on 2/5/19 with diagnoses of Dementia, Insomnia and Chronic Obstructive Pulmonary Disease in part.

R7's EHR Progress Note, dated 2/5/19, documented R7 ambulates independently. R7's Progress Note, dated 2/6/19, documented R7 had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 3.

R7's "SS (Social Service) Abuse/Neglect Screening," dated 2/5/19, completed by V4, Social Service Designee (SSD) assessed R7 to be at high risk for Abuse/Neglect. The Screening documents factors that increase her risk for abuse/neglect as dementia, confusion, and poor judgement.

R7's Care Plan, dated 2/5/19, documents R7 has a behavior problem related to dementia as R7 will

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take on a caregiver role. The Care Plan documents "will attempt to transfer residents, will clear tables of dishes, will push peer resident w/c (wheelchairs)." The goal was R7 was to have no harm to self-related to care giver and no harm be done to others related to her caregiver role. The Care Plan interventions documented the following interventions: "Administer medications as ordered. Monitor/document for side effects and effectiveness; Anticipate and meet the resident's needs; Caregivers to provided opportunity for positive interaction, attention; Stop and talk with him/her as passing by; Explain all procedures to the resident before starting and allow the resident ample time to adjust to changes; If reasonable, discuss the resident's behavior; Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; Intervene as necessary to protect the rights and safety of others; Approach/Speak in a calm manner; Divert attention; Remove from situation and take to alternate location as needed; Monitor behavior episodes and attempt to determine underlying cause; Consider location, time of day, persons involved, and situations; and Document behavior and potential causes." The Care Plan does not address her high risk of abuse/neglect or her being vulnerable sexually due to her nurturing nature and her tendency to touch, rub backs etc. as described by staff members. The facility did not revised and develop a person-centered care plan based on R7's high risk for abuse and neglect. No revisions have been made to the care plan as of 3/15/19.

R7's EHR Progress Note, dated 2/10/19, documented R7's first incidence of wandering for R7 and was entered by V4, SSD "Resident has been wandering the halls frequently today and been wandering into others rooms. Resident has

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been redirected from entering rooms."

R7's Progress Note, dated 2/12/19 at 1:50 PM, written by V17, Social Service Director, documented R7 wandering in/out of other resident's room daily, has severe decision-making skills, and will interfere with resident care and fight staff during periods of confusion.

On 3/14/19 at 9:25 AM, V18, Certified Nurse's Aide, CNA, stated she was working Sunday 2/24/19 and kept seeing R6 going in and out of R7's room. V18 stated she initially thought R6 was rummaging in R7's personal items and had asked him several times to not go into R7's room. V18 stated R7 was in bed and she observed R6 entering R7's room door and slamming the door behind him. V18 stated she ran down the hall knocking/opening the door at the same time to find R6 with his leg lifted getting ready to get on top of R7 while she slept in bed. V18 stated she immediately told V6, Licensed Practical Nurse, that R6 had been going in and out of R7's room all morning and that she had just caught him with the door shut trying to get in bed with R7. V18 stated as she was talking to V6, she saw V2, Administrator coming in the door and informed her as well since she is the facility's Abuse Coordinator. V18 stated she gave V2 the details. V18 stated V2 then gave her permission to immediately move R7 to the 200 hall. V18 stated she moved R7 to the new room herself. V18 stated R6 had taken a liking to R7 shortly after her admission and had been seen repeatedly going in and out of her room prompting them to redirect him numerous times day. V18 stated before finding him trying to get in bed with her, they thought he was just rummaging because he had the behavior of taking others items. V18

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stated she never saw R6 go into R7's room after she was moved to the 200 Hall away from R6's room. V18 stated she couldn't believe they moved R7 back across the hall from R6. V18 stated R6 knew exactly what he was doing.

R7's Progress Note, dated 3/9/19 at 3:57 PM entered by V2, Acting Administrator/Registered Nurse (RN), documents "This writer was notified that resident was observed in her room with peer resident having intimate contact. Residents were immediately separated. Police, POA (Power of Attorney) and physician was notified. Charge Nurse assessed resident for pain and injury and none was noted. This resident was moved to a different hallway and is also on 15-minute checks."

On 3/10/19 at 12:20 PM, V10, Assistant Director of Nurses/RN ADON, stated she was on her way in when she got the call regarding a sexual incident between R6 and R7 described to her as "engaged in sexual intercourse" in R7's room on 300 Hall. V10 stated she informed R7's POA, V14, that an incident occurred but didn't provide details because she didn't know any at the time.

On 3/10/19 at 1:30 PM, V10 identified R6 as the resident found with R7. V10 stated V13, Housekeeper, was the staff member who initially found the two residents together and V6, Licensed Practical Nurse (LPN), was nurse caring for both R6 and R7 as the time of the incident. V10 also stated the facility immediately moved R7 to another hall and implemented 15 minutes checks and put R6 on continuous one-to-one (1:1) observations.

On 3/13/19 at 11:16 AM, V13, Housekeeper,

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stated on 3/9/19 she had found R7's baby doll at the nurse's station and knew R7 would be upset if she couldn't find it. V13 stated she took the doll to R7's room and noted the door was shut which was unusual. V13 stated she knocked/opened the door to find R6 completely naked on top of R7 on the bed and R7 had her pants pulled down to her ankles. V13 stated R6 was in a panic mode, jumped up and grabbed his clothes and R7 just laid there "not really knowing what was going on." V13 stated she started yelling for staff and V6 came running into the room.

On 3/12/19 at 2:55 PM, V6 stated she heard a commotion down the hall and heard V13 yelling. V6 stated when she entered R7's room, R6 was grabbing his clothes and R7 was just lying on the bed. V6 stated R7 did not appear to be physically hurt but upon exam of her peri area, she observed what she thought was semen on R7's pubic hairs. V6 stated the Physician, Police and V14, R7's POA were notified. V6 stated V10, Assistant Director of Nurses (ADON/RN) informed V14 and told V6 that V14 did not want R7 to be sent to the hospital for a rape kit and/or exam. V6 stated she has never known R6 to have any sexual behavior with anyone. V6 described R7 as having severe dementia but being nurturing "loveable huggy in a non-sexual way" and will rub peoples back and touch them sometimes unwanted. When asked if R6 knew what he was doing, V6 stated "absolutely." V6 stated she had never witnessed any inappropriate behavior between the two before but did know he was observed one time standing over R7 in her room while she slept and had shut the door behind him when entering which prompted her (V6) to move R7 to the 200 Hall. V6 couldn't recall the date of the move and stated she did not document it but did confirm the incident was

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reported to V2, Administrator, at the time. V6 identified V18 Certified Nurse Aide (CNA) as the staff member who found R6 standing over R7 in bed and said she didn't understand why they would have moved her back to the hall across from his room knowing this information. V6 stated the alleged rape occurred just a short while after moving R7 back to her previous room which was across the hall from R6's room.

R7's Progress Notes reviewed from 2/23/19 through 3/9/19 do not document any room changes as occurring at all.

On 3/14/19 at 12:15 PM, V22, Activity Assistant, stated on 3/9/19, she was in her room when she heard yelling and ran down to R7's room where V13 was. V22 stated R6 was sitting on the bedside with his pants in his lap covering his genitalia and R7 was on the bed. V22 stated she assisted V6 with a visual exam of her peri area and stated, "You could definitely tell there had been intercourse because there was semen at the vaginal area." V22 stated R6 knew he had done something wrong and in trouble by the way he acted.

On 3/14/19 at 2:10 PM, V24, CNA, stated she was here 3/9/19 the alleged rape happened and was in the room when three staff, V6 the nurse, an activity person and another person (couldn't remember who) were examining her and stating they all saw semen on her and the bed clothes.

On 3/14/19 at 3:20 PM, V20, CNA, stated on 3/9/19, she heard V13 yelling from R7's room and when she entered, R6 was naked grabbing at his clothes. V20 stated she assisted V6 with R7's exam. V20 stated R7 had semen on her panties and in the vaginal pubic hair. V20 stated she

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remembers R7 saying "he was so over powering." V20 stated they had moved R7 off 300 Hall due to R6 being caught standing over while she (R7) slept and she couldn't imagine why they would have moved her back knowing that. V20 stated V21, CNA moved R7 from 200 hall back to 300 hall to her previous room just prior to the incident.

On 3/14/19 at 3:42 PM, V21, CNA, stated she remembers an altercation occurring between two other residents on the 200 hall and having V12 tell her to move R7 back to her old room on 300 Hall around on 3/8/19. V21 stated none of the 3rd shift staff knew about the incident that occurred on 2/24/19 which was the cause of R7 being moved to the 200 Hall. V21 stated that no one's room is changed without V2, Administrator knowing it and giving permission.

On 3/15/19 at 8:10 AM, V25, Police Detective, stated they were called the afternoon of 3/9/19 immediately after the assault occurred and stated it was reported to them that a sexual assault had occurred on a female resident from male resident. V25 stated they were told during interviews with staff that semen was found in R7's panties and in her pubic hair. V25 stated the investigation is still pending and a report is not yet finished.

On 3/12/19 at 3:50 PM, V4, SSD, stated he was unaware of R6 having any sexual behaviors directed toward females or males. V4 states he has never known R6 to seek out R7. V4 was asked if he thought R6 was aware of wrongdoing and responded, "I believe without a doubt in my mind, he knew what he was doing was wrong." V4 continued to stated "I don't think he understood the gravity of the situation" as he has

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impulse control issues. V4 stated he spoke with R6 following the incident and stated R6 said "yes" when asked if he and R7 had sexual intercourse. V4 stated the police did not arrest him nor did the family want to press charges. V4 stated he did not know why R7 was moved to 200 Hall even though V6, LPN, stated he did. V4 stated he understood R7 had two room changes since her admission but was not involved in either one of them.

On 3/13/19 at 10:50AM, V14, R7's daughter/POA stated she was informed of the incident immediately after it occurred and was given very little detail. V14 stated her mother is severely demented and has no safety awareness. V14 stated she could hear her mother talking in the background immediately afterward and she didn't appear to be upset so she told them not to send her to the hospital as she didn't want to upset her. V14 stated her mother is nurturing and has a tendency to want to take care of everything for you. V14 stated her mother is not sexual at all but does touch and rub arms, etc. V14 stated one Friday night when she came in to see her, her mother's hallway door was shut along with the bathroom door in her room. V14 stated she finally checked the bathroom and R7 was not in there. V14 stated she then went out into the hall and asked the CNA (she didn't know his name but described as a black male) if he knew where her mother was." The male CNA stated he didn't and said "Now we've got to look for her where we don't want to find her" going directly to the closed door across the hall from her mother's room. V14 stated R7 was found in the room with R9 who was R6's roommate. V14 stated they were sitting on the bed and nothing sexual appeared to be going on. On 3/14/19 at 5:41 PM, V14 stated she was unsure as to why her mother's room had

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been changed several times during her short stay at the facility. V14 stated she was not notified of those changed or told why they moved her. V14 stated she was told at the time of the call on 3/9/19 that a sexual assault had occurred on her mother by another resident. V14 stated "yes" her mother would have been devastated "had this occurred even 5 years ago."

On 3/15/19 at 11:02 AM, V2 and V3 Director of Nurse (DON) stated neither knew of the incident that occurred on 2/24/19 between R6 and R7 when he was found trying to crawl into her bed as she slept. V2 stated she had been called the evening on 2/23/19, the night before, and told R7 had been going in and out of R6's room and he has inappropriate sexual behaviors. V2 stated she told them at that time to move her to 200 Hall to separate R6 from R9. V2 and V3 stated there is nothing documented in the clinical record regarding it. Both stated an incident report should also have been filed.

R6's MDS dated 2/4/19 identifies him as a 59-year-old male admitted to the facility on 5/21/18 with diagnoses of Schizophrenia in part. The MDS documents R6 to be mildly impaired cognitively with a BIMS score of 12 (8-12 - mildly impaired.) The MDS also documents R6 to be independent in ambulation.

R6's Care Plan revision date of 2/8/19 identifies him to have the following focused areas: physical/verbal aggression and "mood problem r/t sexual activity: resident will offer to perform sexual acts on peer residents" and will come into hall with genitals exposed. There have been no revisions done to R6's behavioral management plans in regard to his inappropriate behavior towards R7 even though it resulted in a room

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change for R7.

On 3/15/19 at 8:48 AM, V16, Medical Director/Physician, stated she was familiar with both R6 and R7. V16 stated she was aware that R6 seemed impulsive in a sexual manner toward females because as she was assessing him, he was trying to touch her the whole time. V16 stated she was unaware of R6's inappropriate behavior toward R7 but her exchange was called on 2/24/19 with a message left which reported an incident occurring between R7 and R6 naming R6 specifically. V16 stated whenever the facility calls her exchange, they get a summary with no details. V16 stated on 3/9/19, she received a call from her on call service reporting a sexual assault on R7 by R6. V16 stated all staff should have been made aware of R6's behavior toward in R7 when the behavior first occurred and certainly after the incident on 2/24/19. V16 stated "having uninformed staff is a dangerous thing and they need to document and communicate better to one another" to prevent this kind of thing from happening again. V16 stated she considered this sexual assault as harm even though R7 is severely cognitively impaired.

The facility's policy/procedure entitled "Abuse Prevention and Reporting - Illinois" dated 11/28/16 documents "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation." The policy documents the Definition of Abuse as "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." The policy documents "Sexual Abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to: unwanted intimate touching of any kind especially of breasts

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S9999	Continued From page 12 or perineal area, all types of sexual assault or battery such as rape, sodomy or coerced nudity," in part. The policy documents "Generally, sexual contact is nonconsensual if the resident is either: appears to want the contact to occur but lacks the cognitive ability to consent; or does not want the contact to occur." (A)	S9999		