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	IL6002844	A. BUILDING: _____ B. WING _____	C 11/05/2020

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ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(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
S 000	Initial Comments Complaint Survey: 2078251/IL127852	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.695c)1) 300.1210 b) 300.1220b)2) 300.3240 a)c)d)e) 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 300.695 Contacting Local Law Enforcement c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 situations requiring local law enforcement notification; 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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	S9999		

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S9999	Continued From page 2 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by: A. Based on interview and record review, the facility failed to follow their policy for abuse investigating and reporting by not immediately suspending employees accused of sexual abuse pending an outcome of the investigation to protect the residents. The facility also failed to follow their policy to immediately report an allegation of sexual abuse to the facility's abuse coordinator and the facility failed to notify law enforcement regarding an allegation of sexual abuse. This failure applies to all 38 residents residing in the facility. These requirements were not met as evidenced by:	S9999		

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The findings include:

The Facility Data Sheet dated October 20, 2020 shows the facility census as 38 residents.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility in March 2018. R1 was transferred to the local hospital on October 16, 2020 and has not returned to the facility. R1 had multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure with hypoxia, protein-calorie malnutrition, heart failure, contractures, acquired absence of right leg above the knee, hypertension, falls, drug induced subacute dyskinesia, and schizoaffective disorder.

R1's MDS (Minimum Data Set) dated September 16, 2020 shows R1 had moderate cognitive impairment, required supervision with setup help only for eating, and extensive to total assistance with all other ADLs (Activities of Daily Living). R1 was always incontinent of bowel and bladder.

On October 22, 2020 at 2:17 PM, V10 (Laundry Staff) stated, "On July 7, 2020 at around 11:30 AM [R1] told me that [V8] (CNA-Certified Nursing Assistant) and [V5] (CNA) had been raping her. After the resident told me, I finished passing out folded clothes to the other residents, for about 30 minutes to an hour. Then I went and told the Director of Nursing." V10 confirmed she (V10) did not immediately report R1's allegation of sexual abuse.

The facility's initial and final State Report of Patient Incident, dated July 7, 2020 shows, "[R1] stated that 5 different males raped her, and that people were wanting to kill her." The incident

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S9999	Continued From page 4 report shows R1 specifically named V5 (CNA), V8 (CNA), V9 (CNA), V11 (CNA), and V12 (CNA) as having "raped her." Facility documentation shows the initial and final abuse investigation was initiated and completed on July 7, 2020 and was sent to IDPH (Illinois Department of Public Health) on July 7, 2020 at 8:42 PM by V2 (DON). The facility did not have documentation to show the local police department was notified of R1's allegation of sexual abuse. On October 22, 2020 at 10:06 AM, V1 (Administrator) said, "I did not suspend any of the staff that [R1] named in her sexual abuse allegation. I did not call the police department. If I really believed it had happened, I would have." On October 27, 2020 at 3:27 PM, V1 (Administrator) said, "If she wasn't confused, and stuck to the same story, we would have called the police. All I can say is that I know our residents. I can say that I know her well enough to say that she was fabricating her story. If it happened to a different resident, I would have to look at the whole picture before I decided to suspend someone or call the police. You have to look at the whole thing. [R1] is an alert and oriented person unless she has a UTI (Urinary Tract Infection). We treated her for a UTI, though we don't have anything to prove she had a UTI. The CNAs weren't suspended because [R1] has only female CNAs assigned to her. But yes, the people she named were present in the building. How can I suspend someone when they don't even take care of her?" The facility did not have documentation to show that R1 had a urinary tract infection.	S9999		

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The facility's documentation shows the facility concluded R1 had a history of behaviors when she had a UTI. The facility treated R1 for a UTI with an antibiotic, though no urine specimen was sent to confirm the diagnosis of UTI for R1, and the facility does not have documentation to support a diagnosis of UTI on July 7, 2020.

The facility's CNA schedule dated June 28 through July 11, 2020 shows V8 and V11 (CNAs) were scheduled to work on July 7 and 8, 2020 from 2:00 PM to 10:00 PM. The same schedule shows V12 (CNA) was scheduled to work on July 7 and 8, 2020 from 6:00 AM to 2:00 PM.

V8's Timecard Report for the period June 28, 2020 to July 11, 2020 shows V8 worked July 7, 2020 from 12:44 PM to 10:01 PM, and July 8, 2020 from 1:50PM to 10:05 PM.

V11's Timecard Report for the period June 28, 2020 to July 11, 2020 shows V11 worked July 7, 2020 from 1:58 PM to 10:01 PM, and July 8, 2020 from 1:52 PM to 10:01 PM.

V12's Timecard Report for the period June 28, 2020 to July 11, 2020 shows V12 worked July 7, 2020 from 5:57 AM to 2:01 PM, and July 8, 2020 from 6:01 AM to 2:01 PM.

V5 (CNA) was named by R1 as one of the perpetrators of sexual abuse. V5 was on vacation on July 7, 2020. V5's time card shows V5 returned to work on July 10, 2020 and worked from 3:39 PM to 10:02 PM. On October 27, 2020 at 10:48 AM, V5 said, "I work second shift, from 2:00 PM to 10:00 PM. I was aware that [R1] made an allegation that she was sexually assaulted by some of the CNAs here. No one

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ever specifically spoke to me about it, nor was I ever suspended. I was never interviewed by anyone regarding the resident's allegation I sexually assaulted her."

On October 27, 2020 at 10:32 AM, V8 (CNA) said, "I work the second shift, 2:00 PM to 10:00 PM. We get assigned to a group of residents, but we do go throughout the building and help each other out. I was not suspended or sent home on July 7 or 8. When [V2] (DON) told me about this situation, I guessed she had done the investigation already and I was in the clear."

On October 27, 2020 at 10:25 AM, V11 said, "I work evening shift 2:00 PM to 10:00 PM. We have groups and we circulate, and we go from one end of the building to the other. In our group we do a lot of teamwork and we do go from group to group, all over the building and help out with other residents. I was assigned to the same unit [R1] resided on during the time of July 7 and 8. I did not have to go into the room that night. I was not suspended or sent home or anything on July 7 or 8, 2020."

On October 27, 2020 at 10:40 AM, V12 (CNA) said, "I work the first shift, 6:00 AM to 2:00 PM. We do go all over the building and help each other, we don't have to stick to just our group. I was here at the facility on July 7, 2020, but I didn't take care of [R1]. I would trade her off to one of the female CNAs. I was not suspended at any time due to her allegation of sexual abuse."

A review of the facility's sexual abuse investigation for R1, completed by the facility on

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S9999	Continued From page 7 July 7, 2020 shows the facility obtained 20 written statements from facility staff, dated and signed by each staff member. Sixteen of the 20 facility staff members' written statements were dated July 8, 2020, the day after the investigation had been completed and reported to IDPH as unsubstantiated due to a UTI. The facility does not have any documentation to show R1 was seen by a physician, or sent to the local hospital, or provided with a head-to-toe assessment by any medical professional including physician or nursing staff, following her allegation of sexual abuse as shown on the facility's policy. On October 20, 2020 at approximately 10:00 AM, V1 (Administrator) said, "I am an old ER nurse. I sent two nurses down there to assess [R1] right away with a flashlight. One of the nurses was [V13]. They did not see any genital redness, bruising, discharge or odor." The facility does not have any documentation by the nursing staff to show an assessment was done of R1's genitalia. On October 28, 2020 at 10:41 AM, V13 (Nurse) said, "I was the nurse caring for [R1] on July 7, 2020 from 6:00 AM to 2:30 PM. Neither [V1] (Administrator) or [V2] (DON) ever told me about [R1's] abuse allegation during my shift. I never examined the resident on July 7, 2020, nor did I notify her physician or family member since I was not aware. I did return to the facility two days later, on July 9, 2020 and I had [R1] for a patient. [V1] (Administrator) asked me to examine [R1] with a flashlight. She's very small so it didn't take long. She's very contracted and it's hard to look at the perineal area. We changed her brief real	S9999		

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quick, and that's how we saw her perineal area. I graduated from nursing school in July 2019. I have never been trained to do a sexual assault exam. We did not document our examination of the resident I just told [V1] I didn't see anything."

The facility does not have documentation to show R1 was examined on July 7, 2020.

On October 27, 2020 at 2:44 PM, V16 (NP-Nurse Practitioner) said, "I was filled in by the facility on July 7, 2020. I remember they called, and they updated me, and I wanted [R1] sent to the emergency room. The vaginal assessment from the nurse was fine is what the facility told me. I texted [V2] (DON) and she said everything was unfounded. According to the [V2], the resident's story was changing. I was told by the facility that the family did not want [R1] sent to the emergency room, but I myself never spoke to the family to confirm that."

On October 28, 2020 at 11:05 AM, V21 (R1's POA-Power of Attorney) said, "In July, [V1] (Administrator) told me that my sister said she was raped. She did not say to me that she wanted to call the police and send her to the emergency room. [V1] told me that her nurses checked her in her private area and she said there was no sign anything happened. I thought it was the nursing home's responsibility to call the police and send her to the hospital. I never said don't send her to the hospital. I never said don't call the police."

On October 27, 2020 at 1:13 PM, V15 (R1's Attending Physician) said, "I was informed that [R1's] allegation was an unfounded allegation. They said there was no evidence of a sexual assault. I was not aware they did not do a

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physical examination of [R1]. At that time, during COVID-19, physicians and nurse practitioners were not going into facilities to see patients. All of our encounters were via telephone or virtual. My nurse practitioner said she was going to treat [R1] for a UTI. [R1] should have been seen by a physician if she made an allegation of sexual assault. We did not give any other orders because the nursing home said there was no evidence for this. The facility said there were no male CNAs working there that night. We were told there were none. If she did name the CNAs, and that was not reported to us, then that was a problem. If someone gives you a name then you should go to the full length of an investigation, that would include sending the patient to the emergency room to do a rape exam. That is not how it was reported to me. It was reported to us that it was a made-up allegation. If it was presented to you incorrectly then you come up with the wrong conclusion."

On October 28, 2020 at 9:33 AM, V14 (Medical Director) said he was told about R1's allegation of sexual abuse by V1 (Administrator). "It was mentioned in a meeting, but this patient is not my patient. After it happened we talked about it in August. I didn't have any conversations per se it was just mentioned that this was going on. It is absolutely my expectation that the facility staff follow the policy for abuse. Otherwise, what's the point of having policies? I would expect them to suspend the staff pending the outcome of the investigation. But as far as plain black and white, you have to follow the policy. I do not think a nurse armed with a flashlight has adequate training to do a sexual assault examination unless they have specific training for it. If this had been my patient, I would have said send her to the emergency room."

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The facility's policy entitled Abuse Investigation and Reporting, revised July 2017 shows, "Policy Interpretation and Implementation, Role of the Administrator: 4. The administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. Reporting: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: e. Law enforcement officials ... 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately."

The facility's policy entitled Abuse and Neglect - Clinical Protocol, revised July 2017 shows, "3. Sexual abuse is defined at 483.5 as "non-consensual sexual contact of any type with a resident. Assessment and Recognition: 1. The nurse will assess the individual and document related findings. Assessment data will include:
a. Injury assessment (bleeding, bruising, deformity, swelling etc.);
b. Pain assessment;
c. Current behavior;
d. Patient's age and sex;
e. All current medications, especially anticoagulants, NSAIDs, salicylate;
f. Other platelet inhibitors;
g. Vital signs;
h. Behavior over last 24 hours (bruise could be related to movement disorder or aggressive

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S9999	Continued From page 11 behavior); i. History of any tendency towards bruising; j. All active diagnoses; and k. Any recent labs." "B" Licensure Violation 2of 2: 300.610a) 300.661 300.3240a) 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 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). Section 300.3240 Abuse and Neglect	S9999		

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview and record review the facility failed to follow their abuse policy for pre-employment screening.

This has the potential to affect all 38 residents residing in the facility.

The findings include:

The Facility Data Sheet dated October 20, 2020 shows the facility census as 38 residents.

During this sexual abuse investigation, V1 (Administrator) provided the employee files of the last ten employees hired for review of pre-employment screening. Of the ten files reviewed, concerns were identified with the employee files of V17 (MDS-Minimum Data Set Coordinator), V18 (Dietary Aide), V19 (Dietary Aide), and V20 (Maintenance Director).

Each employees' date of hire was obtained from the Staff Detail Report, dated October 20, 2020, provided by V1 (Administrator), and the employee's personnel file.

The following concerns were identified:

V17 (MDS Coordinator), Start date: August 24, 2020. State Police background was checked on October 27, 2020, and Healthcare Worker Registry was checked on September 8, 2020.

V18 (Dietary Aide), Start date: September 3,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(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 13 2020. State police background was checked on October 27, 2020, and Healthcare Worker Registry was checked September 14, 2020. V19 (Dietary Aide), Start date: October 5, 2020. State police background check was completed on October 27, 2020. V20 (Maintenance Director), Start date: September 29, 2020. Sex offender website was checked on October 27, 2020. On October 28, 2020 at 9:33 AM, V14 (Medical Director) said he expects the facility to follow their abuse policy. On November 4, 2020 at 12:20 PM, V1 said, "We haven't been doing background checks on new employees before they start working at the facility. We've been doing them the day they start. They come into the building, we have a meeting with them. Then we do the background checks." The facility's Abuse Prevention Program policy, revised in December 2016 shows: "As part of the resident abuse prevention, the administration will: 2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002844	A. BUILDING: _____ B. WING _____	C 11/05/2020

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S9999	Continued From page 14 misappropriation of resident property." "C"	S9999		