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S 000	Initial Comments Incident Report Investigation Facility Reported Incident of 12-27-20/IL129897	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)3) 300.3240a) 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	S9999		

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S9999	Continued From page 1 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) 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	S9999		

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S9999	Continued From page 2 residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement interventions to successfully protect a vulnerable resident (R1) from multiple inappropriate sexual advances by R2 and R3. The facility also failed to prevent two male residents (R2 and R3) with a history of sexual abuse from having continued access to R1 and all other residents on the same wing. These failures have the potential to affect five of five residents (R1-R5) reviewed for Abuse in a sample of fourteen. Findings include: The document titled Abuse Prevention Program dated 11/28/16, states, "This facility affirms the right of our residents to be free from abuse and neglect. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of neglect or abuse of our residents. This is done by: establishing an environment that promotes resident sensitivity, resident security and prevention of neglect and abuse of the resident; Identifying occurrences and patterns of potential neglect and abuse of residents; Dementia management and resident abuse prevention; Immediately protecting residents involved in identified reports of possible abuse; Implementing systems to investigate all reports and allegations of mistreatment, promptly and aggressively, and making the necessary changes to prevent future occurrences. This facility is committed to protecting our residents	S9999		

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from abuse by anyone including other residents. The definition of abuse is instances of all residents, irrespective of any mental or physical condition, cause harm, pain or mental anguish including sexual abuse. Sexual abuse is non-consensual sexual contact of any type with a resident. Neglect is the failure of the facility to provide services to a resident that are necessary to avoid physical harm, mental anguish or emotional distress. Staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of neglect and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis."

The document given to residents when admitted to the facility, titled Resident's Rights for People in Long Term Care, from the Illinois Department of Aging dated 6/09, states, "You must not be abused by anyone - physically, mentally or sexually."

The Facility Assessment, dated 12/11/20, states, "Part 1: Resident Profile Diseases/Conditions, Physical and Cognitive Disabilities (residents that are admitted to the facility) Psychiatric/Mood Disorders: Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Schizophrenia, Behavior that Needs Interventions. Part 2: Services and Care We Offer Based on our Residents' Needs. Resident support/care needs: The facility provided various services for the residents we care for. The residents care is based on their individual needs and preferences and are reflected in the individuals care plan. The care and services

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S9999	Continued From page 4 provided are broken down by category. Mental Health and Behavior: Implement interventionist help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, other psychiatric diagnosis. Provide Person-Centered/Directed Care: Prevent abuse and Neglect; Identify hazards and risks for residents. Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies: Staff type: Mental Health Social Worker; Behavior and Mental Health Providers; Psychiatric Services and Mental Health Providers. General training topics: Abuse, Neglect; Activities that constitute abuse, neglect; Care/management for persons with dementia and resident abuse prevention; Dementia and Behavior de-escalations/redirecting techniques. Attachment 1 Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities (10/04/16) Rules and Regulations; Behavior Health Services - The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." The Final (Five Day) Incident Report, dated 12/31/20, signed by V1 (Administrator) sent to the Illinois Department of Public Health, Long Term Care, stated, "(R1) is a female, (who has a) BIMS (Brief Interview for Mental Status) score of 99 (unable to complete the interview) and with a diagnosis of dementia. (R1) was sitting in (her) wheelchair in the common area of the C wing nurses station fully dressed with jeans and top on. (R2), (who has a) BIMS score of 2 out of 15 (severe impairment), with a diagnosis of Mentally	S9999		

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S9999	Continued From page 5 Handicapped and Dementia was sitting in the common area stacking blocks. (V3) Activity Director (came into the common area) and saw (R2) touching (R1) inappropriately. (V3) immediately stopped (R2) and removed (R1) from the common area and R2 (was taken) to (his) room. V1, V2 (Director of Nursing), the Power of Attorney (POA) and Doctor of each resident (were immediately notified) of the incident. Investigation was completed and the care plan updated; (R1) will be kept at the nurse's station when out in the common area to be monitored. (R2) will be monitored when in common areas and redirected away from female residents." On 1/05/20 at 10:50 AM, V3 (Activity Director) stated, "On 12/27/20 at 11:30 AM, I walked into the common area on the C wing by the nurses' station. I saw (R1) sitting in her wheelchair next to (R2) who was sitting on the love seat. (R2) had his hand down between (R1's) legs. I immediately told (R2) to 'stop that.' (R2) jerked his hand out from (R1's) legs and hunched away. (R2) acted guilty, like (he) knew what (he) was doing was wrong. I immediately took (R1) away from the common area into (R1's) room. Two nurses were at the desk, but both were unable to see what (R2) was doing from their location. I told them what happened and then left as I needed to help another resident go to an appointment. Since (the incident), (R1) sits behind the nurses' desk. (R1) is very confused and doesn't talk." On 1/06/21 at 3:35 PM, V10 (Registered Nurse) by telephone interview, stated, "I could not see the incident from where I was sitting at the nurses' desk. I could see that (R2) was sitting where (he) usually does when (he) watches television. Christmas decorations obstructed my view and I could not see (R1) sitting there. The	S9999		

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first I was aware that something happened was when (V3) told (R2) to stop and called out to (V11/Licensed Practical Nurse/LPN) and myself. I was busy with my residents and was not involved with what happened after that. I don't normally work on the C wing and don't know the residents that live on this wing very well."

On 1/05/21 at 12:20 PM, V12 (Minimum Data Set and Care Plan Coordinator) stated, "We had an IDT (Interdepartmental Team) meeting the day of the incident (12/27/20) and I noted the meeting and preventive measures that were put into place in both (R1's) and (R2's) Care Plans." When asked if (R1's) vulnerability should be addressed in the care plan, V12 stated, "I was not going to, but that's an interesting idea. I should check this for all the residents to see if this is a systemic issue."

On 1/05/21 at 9:30 AM, V2 (Director of Nursing) stated, "I haven't been working here long. (R1) is nonverbal and is unable to tell you how (she) is feeling, although (she) does not appear to have been in distress. (R2) is friendly. (He) likes to walk in the halls."

On 1/05/21 at 10:00 AM V4 (Social Service Director) stated, "This is my sixth week at this facility, so I really don't know all the residents yet. I was told about the incident in December with (R1) and (R2) but cannot say if it has affected (R1) in any way. (R1) is sitting behind the nurses' desk or in bed when I see (her). (R1) isn't able to converse and I'm not sure how much (she) understands when I talk to (her). (She) doesn't show a lot of emotion. I see (R2) walking up and down the hallways a lot. We say hello to each other and I talk with (him) but I really don't know (R2) either."

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S9999	Continued From page 7 On 1/05/21 at 3:05 PM, V1 (Administrator) stated, "(R1) is being kept in the nurses' station where (she) can be observed. I've seen (R1) several times and (she) doesn't appear to be any different than before the incident. I did not realize that (R2) had inappropriately touched (R1) previously. That was long before I started working here." R1's diagnosis include Alzheimer's Disease; Cognitive Communication Deficient; Dementia; Delirium; Psychosis and Depression. R1's current care plan given on 1/05/20 includes the following: Cognitive Loss/Dementia; (R1) has severely impaired cognitive abilities, (R1) has Alzheimer's disease and suffers from delirium. (R1) remains in constant state of confusion and it is difficult to effectively communicate with (her). (R1) often just repeats unclear statements for long periods of time;" and, "Communication; Expressive (R1) only uses understandable words intermittently;" and, "Comfort/Pain, (R1) may not be able to convey feelings of pain due to dementia." R1's Minimum Data Set (MDS), dated 12/09/20 (Annual), Section B0700, Makes Self Understood - 3 - Rarely/never understood; B0800, Ability to understand others - 3 - Rarely/never understands; Section C - Brief Interview for Mental Status - 99 - unable to complete the interview; Section G - Functional Status, Transfers, Total Dependence/Two Plus persons physical assist; E,F, Locomotion on and off Unit - Total Dependence/One person Assist (resident in wheelchair); Range of Motion - 2/2 - Upper extremity Impairment on both sides; Lower extremity, Impairment on both sides.	S9999		

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R1's has Behavior Tracking for: Depression, Tearful episodes in relation to increased anxiety; Psychosis, Self Harm; Depression, Refusing Cares; Depression, Insomnia.

On 11/18/20, V20 (Licensed Practical Nurse) charted in the Nurses' Note, "(R1) is dependent of staff for all cares. One assist transfers."

On 12/24/20 V20 charted in the Nurses' Note, "(R1) is nonverbal; unable to voice needs. Dependent of staff for all Activities of Daily Living. One person transfers."

On 12/27/20 V11 (Licensed Practical Nurse) charted on R1's A.I.M.(Assess, Intercommunicate, Manage) document, "(R1 was) inappropriately touched between legs by (R2). This has occurred before was checked."

On 12/31/20, V20 states, "(R1) is nonverbal and dependent of staff for all activities of daily living. One person assist transfers."

R2's Minimum Data Set (MDS), dated 10/11/20, Section B0700, Makes Self Understood 1 - Usually Understood; B0800 - 1 - Usually Understands; Section G, Functional Status, B. Transfer, Supervision/Set up Only; D. Walk in Corridor, Supervision/Set up Only; E. Locomotion on Unit, Supervision/Set up Only.

R2's Care Plan does not have interventions for inappropriate touching of other residents or how R2 will be monitored when out of R2's room except to redirect R2 away from female residents when in the common area.

On 12/27/20, V11 charted in R2's A.I.M. (Assess, Intercommunicate, Manage) document, "(R2)

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touching (R1) inappropriately over clothes."

R1 is a vulnerable, totally independent resident. R1's Care Plan did not include Potential Harm after any of the incidents R1 was subject to.

On 12/25/20, V20 charted in the Nurses' Note, "(R2) is alert. (R2) ambulates with wheeled walker independently and is independent with transfers."

On 12/31/20 V20 charted in the Nurses Note, "(R2) is independent with ambulation, with use of wheeled wheelchair, independent with transfers."

The Final Incident Report sent to the Illinois Department of Public Health, Long Term Care, dated 10/06/20 and signed by V1 (Administrator) stated, "(R3) is a 69 year old male, with a BIMS (Brief Interview for Mental Status) score of 99 (Resident unable to complete the interview) (and has) a diagnosis of dementia. (R3) was observed lying next to (R1) on (her) bed. (R1) is a 71 year old female with a BIMS of 99 and a diagnosis of dementia. (R1) was fully dressed under the covers and (R3) was in his (disposable brief) on top of the covers with another blanket covering (him). When CNA (Certified Nursing Assistant) walked into the room the two residents were asleep. The staff woke the residents and took (R3) to (his) room. The nurse completed a body assessment on both residents with no signs or symptoms of foul or inappropriate activities. Intervention: (R3) was taken back to (his) room and monitored by staff. (R1) was moved to (another wing) to prevent the incident from happening again. Both parties POA's (Power of Attorney) were notified of incident; MD (Medical Doctor) was notified with no new orders, DON (Director of Nursing) and Administration was

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S9999	Continued From page 10 notified of incident." R3's Minimum Data Set (MDS), dated 10/11/20, Section B0700, Makes Self Understood - 2 - Understood; B0800 - 1 - Usually Understands; Section G, Functional Status, D. Walk in Corridor, Supervision/Set Up. There are no interventions in R3's care plan which address R3 stripping, going into other resident rooms, getting into other resident beds, urinating in places other than the toilet, intimidation of other residents, aggression, redirection difficulties. On 10/06/20, V11 charted in R3's A.I.M. (Assess, Intercommunicate, Manage) document, "(R3) laying in bed (on top covers) partially clothed, sleeping." On 10/09/20, V6 (Licensed Practical Nurse) charted in the Nurses' Note, "(R3) wandering around most of the time. (R3) is nude - redirection and dressed multiple times." On 10/10/20, V5 (Licensed Practical Nurse) charted in the Nurses' Note, "(R3) continues to be naked, removing clothing when dressed again et again." On 10/12/20, V17 (Registered Nurse) charted in the Nurses' Note, "(R3) noted walking in hall (without) anything on this shift." On 10/13/20, V11 charted in R3's A.I.M. (Assess, Intercommunicate, Manage) document, "(R3) observed laying naked in roommates bed with him. Behavior evaluation, changes described: stripping, getting in bed with other residents."	S9999		

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S9999	Continued From page 11 On 10/13/20, V17 (Registered Nurse) charted in the Nurses' Note, "(R3) has been walking in and out of other resident rooms, standing over their beds and staring at them. He has removed all of his clothing before, doing this twice, other residents have complained of feeling threatened by (R3)." On 10/14/20, V5 charted in the Nurses' Note, "(R3) wanders independently. Wanders in et out of others' rooms." On 10/17/20, V11 charted in the Nurses' Note, "(R3) alert with constant confusion, disoriented. (R3) requires constant redirection and reorientation. (R3) continues to come out into hallway without pants or (disposable briefs) on, completely exposing his genitalia. Pants and (disposable briefs) five times over, behavior continues to occur. Speech is garbled, unclear, and nonsensical. Unable to communicate needs." On 10/17/20, V17 charted in the Nurses' Note, "(R3) walking around facility naked and into other resident's rooms, exposing himself, urinating on floors and in corners, spoke with him several times. (R3) does not comprehend anything I've said to him." On 10/18/20, V11 charted in R3's A.I.M (Assess, Intercommunicate, Manage) document, "Increased Inappropriate behavior, wandering. (see Nurses Notes, 10/17/20) Afterwards R3 continued to wander into other resident rooms, genitalia completely exposed. Also observed urinating on floor in other resident's rooms and wandering into other residents' beds and sleeping in them. No orders for change in medications." On 11/01/20 V17 charted in the Nurses' Note,	S9999		

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TIMBERCREEK REHAB & HEALTHCARE CENT	2220 STATE STREET PEKIN, IL 61554

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S9999	Continued From page 12 "(R3) (with) advanced dementia status, continues to wander, is aggressive at times, sometimes enters other resident rooms and is often no-compliant with redirection back to his room or to common areas." On 1/07/21, V16 charted, "(R3) continues to wander into peers' rooms and rummage through peers belongings." On 1/07/21 at 1:40 PM V1 stated, "When I checked there was no behavior tracking being done for (R3)." A summary of the Final, (Five Day) Incident Report sent to the Illinois Department of Public Health, Long Term Care, dated 10/21/20 and signed by V1 (Administrator) stated, "On 10/14/20, V15 (Agency Certified Nursing Assistant/CNA) reported that (R4) had told V15 'Things get awkward when (R3) comes into (R4's) room. (R3) lays in bed with (R5), (R4's) Roommate. (R4) said that he saw shadows of the two men moving around. (R4) also said that both (R3) and (R5) went into the bathroom together and one of the two men peed on the floor. (R4) said he did not see any sexual contact between (R3) and (R5). (R5) said that he wanted to move because (R4) did not want him in the room and would call him names.' (R5) was moved to another room. (R3) is not able to answer questions (due to cognitive impairment). Staff say (R3) needs to be redirected out of other resident's rooms. In a statement written on 10/14/20, (V16/Agency Certified Nursing Assistant) stated, '(R3) has been in (R5), (R13), (R14's) rooms so far this morning.' The intervention was to move (R3) into a room closer to the nurses' station. The investigation determined that the allegations were false."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007330	A. BUILDING: _____ B. WING _____	C 01/14/2021

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S9999	Continued From page 13 On 10/22/20 V11 documented in an A.I.M. (Assess, Intercommunicate, Manage), "(R3) (was) observed laying naked in (R5's) bed with (R5). Behavioral Changes: (R3), getting into bed with other residents." The Final Incident Report sent to the Illinois Department of Public Health, Long Term Care, dated 8/09/19 and signed by V13 (Previous Administrator) stated, "(R1) is a 67 year old female with severe cognitive impairment. Diagnosis include Dementia; (R2) is a 67 year old male with severe cognitive impairment. (V18/Activity Assistant) pushed (R1) to the dining room upon completion of an afternoon activity. (R2) came in and sat down next to (R1). As activity assistant came back through the dining room; she noted (R2) touching the breast of (R1). Immediately (V18) called for a nearby employee who escorted (R1) to (her) nurse and an assessment was immediately performed. No indication observed upon assessment at that time that there was injury physical or mental in nature. (R2) was placed on one on one. (Physicians of both (R1) and (R2) and responsible parties were) notified, as well as local police department officer. (R1's) family member spoke to (V13) that evening regarding the incident. No new orders from physician at this time. In conclusion, Physician (is) to complete medication review for (R2) due to inappropriate sexual behavior and (R2) to be placed on 15 minute checks and 1:1 while in common areas until medical review is complete. (R1) will be visualized by staff when in common areas. Continue to monitor for seven days for signs and symptoms of injury." (B)	S9999		

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