STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005730	A. BUILDING: _____ B. WING _____	C 07/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CROSSING AT AMBOY	15 WEST WASSON ROAD AMBOY, IL 61310

(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 Facility Reported Investigation to Incident of June 21, 2018/IL103795	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.32400a) 300.32400f) 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 Violations**	

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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

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S9999	Continued From page 2	S9999		

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

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 were not met as evidenced by:

Based on interview and record review the facility failed to prevent resident to resident sexual abuse.
This failure resulted in R1 experiencing sexual contact from a male resident.

This applies to 1 of 4 residents (R1) reviewed for abuse in the sample of 4.

The findings include:

R1's May 4, 2018 Minimum Data Set (MDS) showed she was unable to complete the Brief Interview for Mental Status; has short term and long term memory problems; and was unable to recall the current season, location of her room, staff names and faces, or that she is in a nursing home. R1's MDS also showed she required extensive assistance of two people for bed

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mobility and transfers and she was totally dependent on one staff member for moving within her room and for moving from one unit to another within the facility.

R1's Electronic Health Record showed her diagnosis to include: unspecified dementia with behavioral disturbance, difficulty in walking, and restlessness and agitation.

R1's Care Plan with a revision date of April 2, 2018 showed her to be at risk for abuse/neglect due to her cognitive deficit/behavior.

On June 29, 2018 at 9:00 AM, V4 (Housekeeping) stated at approximately 10:00 AM on June 21, 2018 she was traveling from the locked memory unit to the 200 hallway to get wet floor signs. She stated when she rounded the corner of the common area she observed R2 sitting next to R1 near the wall shared with the beauty shop. V4 said R1 was covered with a blanket to the armpit area and R2 had his left arm laying on top of the blanket and across her thighs. She stated R2's right arm was under the blanket to the point of his mid forearm and was on her chest area. V4 stated she went to find another staff member that was able to care for residents. V4 stated she found V7 (Certified Nursing Assistant) in a room on the 200 hallway approximately three rooms down from the common area on the right.

On June 29, 2018 at 9:33 AM, V7 (CNA) stated on June 21, 2018 he was in room 205 making a resident's bed when he was told by V4 that R2 had his hands under R1's blanket. V7 stated within 30 seconds of being told this he approached R1 and R2. V7 said, "I could see his right arm just above the wrist was under the

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S9999	Continued From page 4	S9999		

blanket ...then I pulled the blanket off and his right hand was under her lounging pants and incontinence briefs."

On June 29, 2018 at 2:40 PM, V13 (R1's Spouse) stated, had R1 been cognizant of the incident she "would have been outraged" and she would have had lasting effects from the incident.

On June 29, 2018 at 2:50 PM, V14 (R1's Power of Attorney/Daughter) stated, if R1 knew what had happened to her she "would have been upset ...she was so modest" and "this definitely would have affected her for a long time. If she was aware of it, she would have punched him."

On July 3, 2018 at 9:30 AM, V1 (Administrator) stated abuse is never acceptable to occur in a facility.

The facility's Final Resident to Resident Incident Report Form showed on June 21, 2018 at 9:45 AM abuse was substantiated due to R1 being "unable to provide consent or move away."

The facility's February 7, 2017 Abuse Prevention Program showed "this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment." The policy showed "abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means."

(C)