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	IL6005631	A. BUILDING: _____ B. WING _____	C 09/28/2021

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COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 61455

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S 000	Initial Comments FRI of 9/16/21/ IL138383 - F600 J cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)1)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	**Attachment A** **Statement of Licensure Violations**	

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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: 1) Assigning and directing the activities of nursing service personnel. 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. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to honor a resident's preference for not receiving a shower resulting in staff forcing resident to take a shower against their will for one resident (R1) reviewed for abuse.	S9999		

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S9999	Continued From page 2 This failure resulted in R1 feeling sexually violated and fearful of taking future showers while at the facility. Findings Include: The facility's "Abuse Prevention Program" policy dated 3/5/2009, documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: 2) orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect, and abuse immediately to supervisor personnel. 4) Identifying occurrences and patterns of potential mistreatment." R1's medical record documents that R1 was admitted to the facility on 5/21/21 with a diagnosis of PTSD (Post Traumatic Stress Disorder). R1's current Care Plan documents, "Resident is known/has a history of displaying inappropriate behavior and/or resisting care/services. (A) If resident resisting cares. Ensure resident's safety. Allow time for resident to calm down and re-approach at a later time. Consider changing caregivers." Facility reported incident dated 9/16/21 documents "(R1) who while receiving a shower, became combative with staff stated she was	S9999		

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S9999	Continued From page 3	S9999		

forcibly put in the shower and sexually assaulted. During the entire shower, three CNAs (Certified Nursing assistant), one LPN (Licensed Practical Nurse) and DON (Director of Nursing) were present."

R1's medical record Social Service Director's (SSD) notes dated 9/16/21 document, "Resident (R1) and I spoke about an incident that occurred while staff were trying to get resident to shower. Resident stated they 'staff' forced (R1) to shower and sexually assaulted (R1). (R1) and I spoke about the need for shower and how being physical with staff is inappropriate. I assured resident, management will take the proper steps to take care of the incident. Resident talked with me and calmed down before I walked (R1) back to his room."

R1's medical record SSD notes dated 9/21/21 documents, "Completed quarterly review with resident (R1). Resident has been self isolating and sleeping all day long. Resident kept falling back to sleep during assessment."

R1's medical record Nurses' notes dated 9/19/21 documents, "Resident exhibiting verbal behavior towards staff screaming (R1) is not safe and does not trust facility. When trying to calm resident and reassure (R1), resident (R1) stated that (R1's) been forced to get a shower and (R1) thinks it's an assault."

R1's behavior tracking record dated September 2021 documents, "Target Behavior: Refusing Personal Hygiene. Interventions: 1) Approach in a clam, non-threatening manner. 2) Allow resident time to express self and verbalize frustrations. 3) Ask another staff member to make attempt." R1's behavior tracking documents on 9/15/21 through

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S9999	Continued From page 4 9/19/21, R1 refused personal hygiene with interventions 1-3 attempted with an outcome of an increase in behavior. On 9/22/21 at 11:13 am, R1 was lying in R1's bed. No odors of urine could be detected. R1 began to explain the incident that occurred with R1 in the shower room on 9/16/21 and while explaining the incident of the abuse allegation that took place on 9/16/21, R1 started crying, covered R1's body and face with blankets and stated "I can't believe this has happened to me. I was sexually assaulted. I feel violated. I have rights. I told them 'no' and to stop. I thought when someone is told no and to stop that they're supposed to stop. They wouldn't stop. I kept asking them to stop but they just wouldn't stop. Why wouldn't they listen? I'm afraid of what's going to happen the next time I have to take a shower. Are they going to violate me again? I have rights and they should listen to me." On 9/22/21 at 11:20 AM, V1 Administrator, stated "From what I investigated, (R1) was approached to have a shower because (R1) was soaked with urine and (R1) told the staff no. So they gave (R1) a timeline that day that they would be back to assist (R1) in getting a shower. Three CNAs (Certified Nursing Assistants) took (R1) to the shower room where (R1) became combative not wanting a shower. That's when (V2, Director of Nursing (DON)) and (V8, LPN (Licensed Practical Nurse) went into the shower room to help get (R1) into the shower." On 9/22/21 at 11:27 AM, V2, Director of Nursing (DON) stated, "I walked into the shower room while three CNAs were in the process of undressing (R1). (R1) was throwing a fit and yelling for everyone to get out and saying that	S9999		

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(R1) didn't want a shower, but we told (R1) that we need to do this because (R1) is soaked in urine. (R1) started to let the CNAs take (R1's) pants off, then decided (R1) didn't want a shower and didn't want them to undress (R1). (R1) was cooperative one second, then was telling us (R1) didn't want a shower the next. The CNAs finally got (R1) undressed and into the shower. When (R1) started washing (R1), I stepped out. (R1) kept repeating 'This is ridiculous, I don't need a shower, I don't have to take one' while I was in the shower room."

On 9/22/21 at 11:44 AM, V4, CNA, verified R1 did not want to take a shower and stated "The days leading up to 9/16/21, (R1) was completely soaked in urine along with (R1's) bed. We tried to get (R1) to take a shower but (R1) refused. On 9/16/21 at around 9:45 AM, (V8, LPN) told (R1) that (R1) needs to take a shower and that we were giving (R1) until 10:00 AM to go to the shower on (R1) own. When (R1) didn't shower, (V6, CNA, and V8, LPN) went into (R1)'s room and got (R1) out of bed and into the shower chair. R1 started becoming combative and fighting everyone yelling, 'I don't need a shower. This isn't right.' After we finally got (R1) into the shower room, (R1) started fighting me when I was taking trying to take (R1's) pants off saying, 'They are sexually assaulting me'. Once we got (R1) undressed, we got (R1) in the shower but (R1) refused to wash (R1). That's when I went ahead and washed (R1's) legs, armpits and private area. As I was washing (R1), (R1) kept saying, 'This isn't right. You're sexually assaulting me'."

On 9/22/21 at 11:54 AM, V5, CNA stated, "I was a shower aide the day of the incident. I was told to try and get (R1) in the shower. The nurse wound up giving (R1) 30 minutes to get into the shower. I

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left the room and to grab linen and when I got back, (V4, CNA and V6, CNA) were explaining to (R1) why (R1) needed to take a shower. We tried to get (R1) up, but (R1) started kicking, scratching, punching and biting at staff and refusing to shower. I left the room again to go down the hall to get a shower chair. When I returned, (V6, CNA, and V8, LPN) got (R1) out of bed, while (R1) was still fighting, and into the shower chair. (R1) is capable of walking on (R1's) own. The reason we used the shower chair was to transport (R1) to the shower room since (R1) wouldn't go on (R1's) own. Once we got (R1) into the shower room, (R1) let us take (R1's) shirt off without an issue, but then wouldn't let us take (R1's) pants off. (R1) crossed (R1's) legs and didn't want them removed. After we finally got (R1) undressed, (V4, CNA, and V6, CNA) started washing (R1). While they were washing (R1), (R1) kept saying. 'This isn't right. This is sexual assault.' After (R1) got showered, (R1) didn't fight us anymore."

On 9/22/21 at 12:01 PM, V6, CNA, stated, "On 9/16/21, (R1) was soaked in urine. We kept telling (R1) that (R1) had to shower, but (R1) refused. Then (R1) started yelling and screaming at us. (V8, LPN) and I put our arms under (R1) and stood (R1) up and transferred (R1) to the shower chair. Actually, we had to pull (R1) up because (R1) refused to get up. (R1) was biting, kicking, and punching us. (R1) started crying and kept repeating, 'This isn't right.' (R1) is ambulatory and able to go to the shower on (R1) own. We had to use the shower chair to transport (R1) to the shower room because (R1) refused to go. Once we got (R1) to the shower room, we undressed (R1) and got (R1) into the shower. (V4, CNA) and I had to wash (R1) because (R1) refused to wash (R1's) self."

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S9999	Continued From page 7 On 9/22/21 at 2:00 PM, V1, Administrator, verified forcing R1 into a shower was not an appropriate approach and stated, "I'm not sure what the back story for (R1)'s PTSD (Post traumatic stress disorder) is. Looking back at the situation, we should have tried a re-approach or alternate methods to get (R1) to shower. If the residents continue shower refusals, we normally look at the care plan for the interventions. If the interventions listed for that particular resident don't work, we look at modifying the interventions or we try to get the family involved." On 9/22/21 at 2:17 PM, V7, Social Services Director (SSD), verified that R1 has PTSD (Post traumatic stress disorder) from a history of sexual abuse and stated, "I spoke to (R1) after the incident and (R1) is very upset about what happened. (R1) started crying and telling me how it wasn't right what the staff members did. I'm sure (R1) being washed against (R1's) will triggered (R1's) experience of sexual abuse and (R1) had to relieve that pain. That had to be a traumatic experience for (R1)." On 9/28/21 at 10:00 am, V1, Administrator, stated "We use the Ombudsman's Resident Rights handbook for residents right to refusals. The Ombudsman Resident Rights handbook documents, "You have the right to make your own choices. You have the right to request, refuse, and/or discontinue any treatment." (B)	S9999		