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
	IL6015879	A. BUILDING: _____ B. WING _____	C 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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S 000	Initial Comments Investigation of Facility Reported Incident of May 17, 2021/IL134214	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690 a), b), c) 300.3240 a), b), c), d), e) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 occurrence. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. 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. 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. 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. This REQUIREMENT is not met as evidenced by: These failures resulted in three deficiency statements. I. Based on interview and record review the facility failed to ensure a resident was free from abuse by staff. Staff witnessed a Certified Nurse's Assistant (CNA) V15 inappropriately interacting with a resident (R4). The facility continued to schedule V15 to provide personal care of R4 on numerous occasions following the	S9999		

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S9999	Continued From page 2 abuse incident. This failure affects one of three residents (R4) reviewed for abuse in the sample of five residents. II. Based on interview and record review the facility failed to protect residents from abuse by: failing to recognize an allegation of sexual abuse between staff and a resident, failed to initiate an investigation into the allegation of sexual abuse and failed to remove the alleged perpetrator from continued direct care of a resident for one five residents (R4) reviewed for abuse on the sample list of five. This failure resulted in the V15 Certified Nursing Assistant (alleged perpetrator) continuing to provide personal cares for R4 for 24 shifts with no determination if sexual abuse of R4 by V15 had occurred. This failure also had the potential to affect all 75 residents residing in the facility as V15 continued to work having access to all residents at the facility. III. Based on interview and record review the facility failed to report allegations of sexual abuse immediately to the Administrator for one of five residents (R1). Findings include: 1. On 6/1/21 at 12:06 PM, V9 Certified Nurse's Assistant (CNA) stated on Saturday March 27th at 4:00 PM, V9 walked in to R4's room. V9 stated V15 CNA was in bed with R4. V15 had R4's genitals in V15's mouth. V9 stated V15 jumped up out of R4's bed. V9 stated V9 and V15 had a weird three second pause. V9 stated V9 didn't say anything and that V9 left the room and went straight to V1's (Administrator) office. V9 stated V9 reported what happened immediately to V1. V9 stated V9 told V1 that V15's head was down below R4's waist and R4's pant leg was pulled up	S9999		

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enough to have R4's genitals exposed. V9 stated V9 insinuated that V15 was giving R4 oral sex. V9 stated V15 is really focused on R4's care. V15 likes to exclusively claim R4's showers. V9 stated V15 will stay over just to give R4 a shower. V15 makes it a point to take care of R4. V9 stated V15 is still caring for R4 and has been giving R4 showers. V9 stated, "I am 100 percent sure that is what V15 was doing."

R4's Quarterly Minimum Data Set Assessment form dated 4/23/21 documents R4 has a diagnosis of Amyotrophic Lateral Sclerosis (progressive neurodegenerative disease) and requires extensive assistance with bed mobility, transfers, dressing, hygiene, and toilet use.

On 6/2/21 at 1:28 PM, V1 stated on Saturday, March 27th, 2021 around 4:00 PM, V9 came to V1's office to report that V15 was found in bed with R4. V1 stated V1 did not do an abuse investigation. V1 stated V1 did ask V15 and R4 what happened, and both stated that R9 found R4 and V15 in R4's bed together. V1 stated V1 told V15 that V15 is no longer allowed to provide cares to R4. V1 stated V15 was not suspended pending an investigation. V1 stated V1 did not follow-up with anyone to ensure V15 was not working with R4.

On 6/2/21 at 2:06 PM, V15 stated V15 began working in the facility in December of 2020. V15 stated V15 did not know R4 prior to working in the facility V15 stated that V15 and R4 joke around with each other. V15 stated R4 would tell V15 if R4 had a bad day and V15 took care of R4. V15 stated V15 was on that R4's hall a lot. V15 stated V15 only remembers that day (3/27/21) vaguely, V15 stated V15 was working overtime. V15 stated V15 remembers it being R4's birthday.

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V15 stated V15 gave R4 a shower because R4 was going to have a visitor that day and we (V15 and R4) wanted to make sure R4 was cleaned and dressed for R4's visit. V15 stated sometime in the afternoon R4 had hit the call light and V15 had answered it. V15 stated V15 gave R4 a urinal and told R4 to "hit the light" when R4 was done. V15 stated V15 went and got someone else up and R4 turned the light back on. V15 stated V15 reentered room, took the urinal, emptied it, and turned off the call light. V15 stated V15 told R4 that V15 was exhausted. V15 stated R4 and V15 were the only two in the room at that time. V15 stated R4 wiggled over and V15 got into bed with R4 and laid down. V15 stated the privacy curtain was pulled. V15 stated then V9 came in and V15 got up abruptly because V15 knew it could have been perceived as something else. V15 stated people would have thought V15 was doing something more. V15 stated V9 would have been at the foot of the bed when V9 came around the privacy curtain. V15 stated V9 would have seen them in the bed from the feet up. V15 stated they (V15 and R4) weren't covered up. V15 stated V15 had the sheet covering R4 to the waist. V15 stated V9 just stood there looking at them and didn't say anything. V15 stated V15 just looked at V9 and got up and walked past V9 and left the room. V15 stated as V15 was getting another resident up V1 Administrator came and told V15 that V1 needed to talk to me. V15 stated V15 and V1 went to V1's office. V15 stated V1 asked V15 what occurred and V15 told V1 that against V15's better judgement that V15 had laid down in R4's bed. V15 stated V1 told V15 that V15 couldn't be on the hall or take care of R4 again. V15 stated after that day V15 was scheduled on the hall in which R4's resides and V15 has provided cares to R4 since then. V15 stated V15 has also given R4 showers. V15

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stated no one told V15 that V15 could care for R4 again but V15 assumed V15 could because V15 was scheduled down there. V15 stated sometimes V15 was the only CNA scheduled on that hallway. V15 stated it would be impossible for V15 not to care for R4 when V15 was scheduled down that hall by herself. V15 stated V15 and R4 are friends and they would talk about music, movies, and cartoons. V15 stated V15 has R4 on two social media applications. V15 stated other staff may perceive our (V15 and R4) relationship as more. V15 stated V15 thinks the other staff may have been suspicious because V15 would offer R4 food such as pizza and diet (soda) out of V15's own money. V15 stated V15 got R4 a bird feeder for R4's birthday because R4 likes watching birds. V15 stated V15 was just trying to make R4 feel special on R4's birthday. V15 stated V15 and V9 have a good working relationship and have had no issues working with each other.

On 6/2/21 at 1:28 PM, V1 stated after V9 came in and reported that V15 and R4 were lying in bed together, V1 talked to both R4 and V15. V1 stated V15 and R4 told V1 that they were laying in R4's bed together joking and talking. V1 stated V1 told V15 that it was not appropriate, and that V15 was the care giver and V15 needs to keep it professional. V1 stated V1 told V15 that V15 could absolutely not care for R4 anymore. V1 stated V1 realized laying in bed together was not appropriate so decided to prevent the potential for V15 to cross a boundary with R4. V1 stated going forward V1 didn't want V15 to take care of R4. V1 stated V15 was moved off of the hallway and V1 talked to V19 (scheduler) and had V15 taken off that hallway. V1 stated if V15 was on that hallway, V15 wasn't supposed to take care of R4. V1 stated V1 made it clear that R15 should not be

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taking care of R4. V1 stated V1 hasn't asked if V15 has been in R4's room or scheduled on that hallway.

On 6/2/21 at 10:11 AM, V19 Social Service Director/Scheduler stated V19 is the scheduler for the facility. V19 stated V15 will float and works all the halls in the facility. V19 stated V19 was told V15 was not allowed to work with R4 at the end of March. V19 stated V19 scheduled V15 on that hallway but assumed V15 was not working with R4.

March, April, and May 2021 monthly calendars provided by V19 documents V15 worked on the same hallway as R4 on 3/31/21, 4/1/21, 4/2/21, 4/5/21, 4/7/21, 4/8/21, 4/10/21, 4/11/21, 4/13/21, 4/15/21, 4/18/21, 4/19/21, 4/21/21, 4/22/21, 4/23/21, 4/29/21, 4/30/21, 5/3/21, 5/13/21, 5/17/21, 5/21/21, 5/22/21, 5/23/21, and 5/26/21.

On 6/2/21 at 12:57 PM, V13 CNA stated R4 has a friend (V22 Dietary Aide) that had started working in the kitchen. V13 stated V15 would ask V22 questions about R4 prior to R4 being at the nursing home. V13 stated V15 would be in R4's room for long periods of time. V13 stated V15 didn't notice it with other residents, mainly with R4. V13 stated R4 is friendly but it seemed like they (R4, V15) spent more time together. V13 stated V9 is credible and V13 has no reason not to believe what V9 says.

On 6/2/21 at 1:28 PM, V22 Dietary Aide stated V22 has worked at the facility since January 27th of 2021. V22 stated V22 knew R4 before employment at the facility. V22 stated V22 and V22's spouse are really good friends with R4. V22 stated V15 talks about R4 a lot. V22 stated V15 would often mention R4 and joke and say things

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like, "you could cook for (R4) and I will take care of (R4)." V22 stated V15 wouldn't stop talking about R4. V22 stated she felt the amount she talked about him was weird. V22 stated V15 would call V22 her "bestie" because of R4 even though V22 had never even talked to V15 outside of work. V22 stated they (R4 and V15) are friends on social media. V22 stated V15 had told V22 that V9 had turned V15 in for messing with R4 but everything was ok. V22 stated V15 was still taking care of R4 after that.

On 6/2/21 at 10:57 AM, V18 Licensed Practical Nurse stated a couple weeks ago or longer V9 told V18 about the incident between V9 and R4. V18 stated V18 asked if V9 reported it and V9 said yes. V18 said that V9 walked into R4's room and R15 was laying in bed with R4 talking and R15 jumped out of bed. V18 stated V18 wanted V9 to report it because it is just something that they (staff) don't do. V18 stated V18 would want it investigated to make sure nothing was going on. V18 stated no one asked V18 about the incident until 6/1/21.

V15 was suspended pending an investigation on 6/1/21.

2. R1 serious injury incident report dated 5/17/21 documents R1 reported an allegation of sexual abuse by a staff member to V1 Administrator on 5/17/21.

On 6/1/21 at 3:37 PM, V8 Certified Nursing Assistant stated R1 told V8 that R1 was raped. V8 stated V8 didn't tell anyone about R1's allegation of abuse. V8 stated the next day V1 talked to me and in-serviced me that I should report all allegations immediately.

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S9999	Continued From page 8 On 6/1/21 at 10:25 AM, V1 Administrator stated V8 knew of the allegation the night before (5/16/21) but did not call or report it. V1 stated V8 should have reported the allegation immediately. The facility's Abuse Prohibition policy with a revision dated of 11/28/19 documents under B. Initial steps and reports of alleged abuse or neglect that, "1. Facility agent or employee that becomes aware of alleged abuse or neglect of a resident should report the matter immediately to the facility Administrator or designee. (B)	S9999		