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
	IL6008866	A. BUILDING: ______ B. WING ______	C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Investigation of Facility Reported Incident of 6-12-21/IL134992	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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care needs of the resident.

Section 300.3240 Abuse and Neglect

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 protect a resident from sexual abuse for one (R1) of four residents reviewed for abuse in a sample of eight. This failure resulted in R1 being sexually abused on 6/12/21 by R2.

Findings include:

Facility "Abuse Prevention Program Facility Procedures" policy, undated, documents "This facility desires to prevent abuse, neglect, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment."

Facility "Final Incident Investigation Report," dated 6/16/21, documents "On 6/12/21 it was reported that (R1) had been inappropriately touched by another resident (R2). Staff were playing music for the residents and all were dancing including (R1). (R2) approached (R1)

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and pressed his palm against her breast."

Facility interview with R2, undated, documents "(R1) seems like a nice woman, and I thought she would like it. She seemed to enjoy it."

R1's face sheet documents R1 was admitted on 10/23/20 and has a diagnosis of Dementia. R1's Minimum Data Set, dated 6/15/21, documents R1 is rarely/never understood, and has a memory problem.

R2's face sheet documents R2 was admitted on 1/18/17. R2's Minimum Data Set, dated 4/6/21, documents R2 is cognitively intact.

R2's current care plan documents a focus of "I have a behavior problem. (R2) is noted to make inappropriate sexual comments to staff and some other female residents" and a goal dated 7/7/21 of "I will not make inappropriate comments to staff or residents."

R2's behavior monitoring for April, May and June 2021 documents R2 is being monitored for Socially Inappropriate Behavior and has instances of Socially Inappropriate Behavior documented for each month.

R2's "Psychological Services Progress Note," dated 2/11/21, documents "(R2) would have stayed at (other facility), however was asked to move due to his inappropriate behavior of sexual nature with staff as he would touch or slap women's body parts. He says he must behave now."

On 6/17/21 at 11:10am, V1 (Administrator) stated "An abuse allegation report was made to me by V2 (LPN/Licensed Practical Nurse) on 6/12/11

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regarding (R1) who is confused and (R2). At the time of the incident (6/12/21) both (R1) and (R2) were on the 4th floor. (R1) is a fairly young resident who has small perky breasts, and (R1) has advanced dementia. (R2) propels himself around the unit by his wheelchair. On Saturday (6/12/21), (R1) was dancing at the nurse's desk and (R2) went up to (R1) and touched (R1's) breast with his hand. (R2) did this in front of staff at the nurse's desk. When I interviewed (R2) he claimed he thought (R1) wanted the sexual advances. (R2) has been here about five years and always been in a private room because he has behaviors."

On 6/17/21 at 11:50am, V4 (CNA/Certified Nurse Aid) stated "I was working on 6/12/21, and (R1) was in the hallway and (R2) touched her breast. I told (R2) he couldn't do that and he went to his room. (R2) is inappropriate with staff verbalizing sexual comments but does not touch. I tell the nurse if we have any sexual verbalizations from (R2)."

On 6/17/21 at 12:31pm, V3 (CNA) stated "I was working on 6/12/21 and was at the nurse's desk where (R1) was dancing in the hallway. (R2) came down the hallway in his wheelchair, and stopped in front of (R1) and put his hand on her breast. I and other staff immediately separated (R1) and (R2) and told (R2) to not touch (R1). (R2) put one hand on (R1's) breast. I reported it to V2 (LPN), and V2 documented and told management about the incident."

On 6/17/21 at 2:30pm, R2 stated "I got in trouble for touching a gal." At that same time, R2 verified he was not to touch people inappropriately or say sexual things to people.

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S9999	Continued From page 4 On 6/22/21 at 10:50am, V2 (LPN) stated "(R2) does have sexual behaviors and (R1) has severe dementia. I was working 6/12/21 from 6-2:30pm when (R1) was dancing at the nurse's desk and (R2) came wheeling himself down the hall and reached out and grabbed (R1's) breast with one hand. I directed (R2) back to his room and (R1) was taken to the other end of the hall. I called V1 (Administrator/Abuse Coordinator) and I then spoke to (R2) that he couldn't touch residents and that it was inappropriate. (R2) acted deliberately to touch (R1's) breast at the nurse's desk, and (R1) was moved to a different floor that day." (B)	S9999		