STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000780	A. BUILDING: _____ B. WING _____	C 12/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-BEARDSTOWN	8306 ST LUKES DRIVE BEARDSTOWN, IL 62618

(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 Incident of 12/4/21/IL140995	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)2) 300.3240a) 300.3240b) 300.3240c) 300.3240e) 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	**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: 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) 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 and to the Department. (Section 3-610(a) of the Act) e) When an investigation of a report of suspected abuse of a resident indicates, based	S9999		

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S9999	Continued From page 2 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 observation, record review and interview, the facility failed to identify a resident as high risk for sexual abuse and to monitor increasing sexual behaviors directed towards female residents by R1, and to investigate and report an allegation of sexual abuse as reported to the former administrator on November 13, 2021. This resulted in the facility failing to develop interventions to prevent further sexual abuse and to develop a plan to monitor and supervise R1's sexually driven behaviors effectively, allowing R1 to grope R2's breast on 12/4/2021. These failures have the potential to affect all 41 female residents (R2-R42) that currently reside in the facility. Findings include: The facility policy, titled "Resident Care Policy and Procedure regarding Abuse and Neglect, Involuntary Seclusion, Exploitation, Misappropriation of Resident Property, Injuries of Unknown Origin, and Social Media (revised 3/15/18)" documents, "All residents have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, involuntary	S9999		

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S9999	Continued From page 3 seclusion, neglect, misappropriation of property and exploitation." The Policy defines Sexual Abuse as "non-consensual sexual contact of any type, which includes, but is not limited to sexual harassment, sexual coercion or sexual assault. (42 CFR 483.13 (b) (guidance) Sexual coercion shall include any intentional or knowingly touching or fondling a non-consenting resident's sex organs, anus or breast either directly or through clothing for the purpose of sexual gratification or arousal of the accused." In the same policy, under "Resident as Perpetrator of Abuse", it documents "1. When an allegation of suspected abuse is received 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. 2. If another resident is the suspected perpetrator of the abuse, then the suspected resident shall be supervised 1:1 or kept physically separate from all other residents until further orders. 3. If the incident involves alleged abuse by another resident of the facility as the perpetrator of the abuse, then the Administrator shall take all steps necessary to protect all resident in the facility from abuse until the alleged perpetrator can be evaluated." In the same policy, under "Reporting - Allegations of Abuse and Neglect," it documents "1. A facility employee or agent or covered individual who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility Administrator. 2. A facility Administrator who becomes aware of alleged abuse or neglect of a resident shall immediately report he matter by telephone and in writing to the resident's representative. 3. If the incident involves alleged	S9999		

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S9999	Continued From page 4 abuse, neglect or incident of unknown origin, the incident will immediately be reported to the Administrator and the Administrator shall provide the Illinois Department of Public Health with initial notice of the alleged abuse, neglect, or incident of unknown origin by telefaxing to the Department a copy of a report of the incident completed immediately after the incident becomes known." The Policy further documents, under "Investigating Abuse," that "1. After an initial report of suspected abuse or neglect is sent to IDPH (Illinois Department of Public Health), the Administrator or designee shall investigate all alleged incidents of abuse or neglect. 2. The investigation shall include, if possible: (a) Interviews with all involved parties and potential witnesses. If possible, at least tow interviewers shall be present of each witness interview. At least one interviewer shall take notes. (b) When possible, the investigation shall include signed statements from those persons who saw or heard information pertinent to the incident. Statements should be taken from the suspect, the person making the accusations, the resident abused or neglected (if cognitive level permits), other staff or residents who may have witnessed the incident, and any other person who may have information related to the incident. (c) All witnesses will be informed of their duty to report suspected abuse and neglect." Additionally, the Policy advises, "3. The Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to the Illinois Department of Public Health." The electronic medical record documents R1 has the diagnosis of Age-Related Cognitive Decline. A Minimum Data Set assessment, dated 10/07/21, documents R1 has moderate cognitive impairment and utilizes a wheelchair for	S9999		

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S9999	Continued From page 5 mobilization. R1's current Plan of Care documents R1 as "Sexually inappropriate: at times, resident will make sexually inappropriate comments towards staff and peers (initiated on 4/07/21) " and "I (R1) have the potential to demonstrate verbally inappropriate behaviors towards staff and my peers." Nursing Progress Notes document R1 displayed increased sexually inappropriate verbal behaviors towards staff on 11/09/21, 11/12/21 and 11/13/21 throughout the day. R1's Nursing Progress Notes by V9 (Licensed Practical Nurse), dated 11/13/21 at 6:29 pm, document "Resident was in front of Nurses station in his wheelchair when a Female resident with Dementia and Vision impairment came walking by. (R1) said 'Hey come here' The Female Resident leaned her head down slightly to hear what he had to say. (R1) then kissed her on the cheek. Female Resident walked away then (R1) started yelling at her 'Hey, hey'. She turned around toward him and he then pointed toward his room. This Nurse explained to (R1) that his behavior is inappropriate, and he cannot be kissing on other female residents. (R1) replied 'How about you then? Do you want to come to my Room?' I replied No and please do not talk to me like that. I do not like it. (R1) continued to holler at female staff and female residents that passed him in hall stating 'Hey, Honey do you want to come to my room?' He would also reach out and place his hand on their arm, hand, or leg as they walked by. I talked with (R1) several times about his behavior without any success." This Nurse then took him to his room to watch TV. Call light placed in reach." Nursing Progress Notes document the facility Administrator at that time (V10), was notified of R1's behaviors at 7:02 pm, on 11/13/21; however, there is no documented evidence the incident was	S9999		

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S9999	Continued From page 6 investigated or reported to the State Agency, residents were questioned regarding the incident, and no changes to R1's plan of care were made to ensure R1 was monitored for his behaviors and adequately supervised. Nursing Progress Notes, dated 11/14/21, document R1 continued to make sexually inappropriate comments to staff, asking if he could "play" with their breasts. The same day, at 11:04 am, Nursing Progress Notes document, "(R1) sitting in hall and another resident (unknown) walking by and he reached out to her to pull her down to kiss her. Non-(pharmacological) interventions: Redirected before able to kiss the resident." On 11/15/21, Nursing Progress Notes document the physician was notified of R1's increasing sexually inappropriate behaviors. On 11/16/21, R1's Nursing Progress Notes document, "Inappropriate comments made to another resident (unknown) in hallway." On 11/17/21, Nursing Progress Notes document, "(R1) telling female staff and residents (unknown) he needs a kiss. Advised resident his behavior was inappropriate and to stop immediately. Interventions successful at this time." There is no documentation to identify which specific female residents R1 directed his sexually inappropriate behaviors towards. Physician's Orders, dated 11/17/21, document R1 was prescribed Prozac 10 mg (milligrams) daily, because of his inappropriate sexual behaviors. R1's Plan of Care still failed to address that his sexually inappropriate behavior had now progressed to inappropriately touching female residents, and no interventions had been developed to protect other residents from R1's behavior. The facility was unable to provide any documentation that could identify which residents were the target of the	S9999		

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S9999	Continued From page 7 behaviors described in R1's Nursing Progress Notes. On 12/08/21 at 12:51 pm, V9 (Licensed Practical Nurse) stated R1 has been known to "joke with staff inappropriately" in the past; however, V9 stated for a couple of weeks in November 2021, while R1 was being treated with an antibiotic, his behaviors were "out of control." V9 stated on 11/13/21, she observed R1 ask R4 to come closer to him, and when R4 leaned into him, he kissed her on the cheek. V9 stated R4 just "shook her head and walked away." According to V9, R1 remained in the hallway near the nurse's station, and for a period of 15 minutes as he continued to grab at female residents as they walked by. V9 stated R1 would say things such as, "Hey, Honey, come into my room" and "let me feel you up." V9 recalled that R1 grabbed R3 on her arm as she wheeled by in her wheelchair, and R3 did seem upset. V9 stated she later checked on R3 who was in her room at the time and advised her they would be watching R1 closer. V9 stated she immediately notified the facility's previous Administrator (V10) of what had occurred with R1, because she was concerned it was sexual abuse. V9 stated V10 told her to notify both R1 and R2's families of the incident, which she did, and that she was aware that R1 had been having increased sexual behaviors. V9 stated the V10 told her she was discussing with the family and physician which medication to place R1 on, and for the CNAs (Certified Nursing Assistants) to "keep an eye on (R1)." V9 stated V10 did not ask her which female residents were the target of R1's sexual behaviors, and was only told to have the "CNAs (Certified Nursing Assistants) keep an eye on (R1)." V9 concluded that V10 did not ask her any specifics regarding which residents may have been affected by R1's	S9999		

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S9999	Continued From page 8 behaviors that day. On 12/08/21 at 1:24 pm, R3 stated she recalled the day a few weeks ago when R1 was in the hallway and making a "fuss." R3 stated R1 did grab her that day, as he wheeled up to her, saying "he grabbed me, alright, right on my boobs." R3 stated he did scare her and she "might still be afraid." R3 stated the nurse working did talk to her after it happened, "she knew I was upset." R3 stated she didn't tell the nurse that R1 grabbed her breast that day, and the nurse just thought he grabbed her arm. R3 concluded that no one else asked her about the incident, and she didn't tell anyone what happened. R3 stated only the nurse (V9) working talked to her about what happened that day, and "if anyone else would have asked, I would have told them where he grabbed me (breasts)." On 12/08/21 at 1:31 pm, R4 stated R1 did get her to lean in towards him, like he was going to say something, and he kissed her on the cheek. R4 stated R1 apologized, and she feels he didn't mean harm, but it made her uncomfortable. On 12/07/21 at 10:17 am, V4 (Licensed Practical Nurse) stated she overheard about three weeks ago that R1 tried to touch a female resident right by the entrance into the facility, but a CNA intervened before he could do so. Does not know any other details, including where he tried to touch her. Staff are aware that R1 must be closely monitored, as he will ask female residents for a kiss, try to hold hands with them, and say "do you want to lay down with me?" On 12/04/21, at 6:35 am, Nursing Progress Notes	S9999		

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S9999	Continued From page 9 document, "Housekeeper witnessed inappropriate sexual behavior from (R1) to another (R2). They were immediately separated. (R1) was not harmed/injured. No on-call list at desk, so ADON (Assistant Director of Nursing) was called and left voice mail to call (facility) as we needed new (Administrator's) phone number." An Initial Incident Report to the Health Department, dated 12/04/21 at 6:30 am, documents "On Saturday December 4, 2021, (R1) was involved in a resident to resident incident at the facility. A witness reported observing (R1) physically touch (R2) on the chest. (R2) began to move her wheelchair backwards away from (R1). Witness immediately separated residents and verbally counseled (R1) that the physical incident was not appropriate. Witness then reported this incident to the Administrator abuse coordinator and the nurse. The facility nurse reported to the (Primary Care Physician), (Power Of Attorney), performed physical assessment, and initiated visual monitoring on (R1) to ensure the incident would not recur. No (signs or symptoms) of injury observed and (R2) denies any harm. Final report to follow within 5 days." A Minimum Data Set Assessment, dated 11/18/21, documents R2 has the diagnosis of Dementia without Behavioral Disturbance and moderate cognitive impairment. On 12/07/21 at 11:13 AM, V8 (Housekeeping) stated, on the morning of 12/04/21 she was walking out of the restroom located near the dining room. At that time, she saw R1 and R2 sitting in their wheelchairs talking as they waited to go into the dining room for breakfast. V8 stated she saw R1 quickly reach out to R2 and grab her breast. V8 stated, R2 immediately said	S9999		

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S9999	Continued From page 10 'Hey' and started propelling away. V8 indicated "it was over in seconds." V8 separated R1 and R2 even further and immediately told nursing staff. V8 stated R1 is known to say inappropriate things, like "you don't have on a bra" to other female residents, but she had never witnessed him touch a female resident before. The Electronic Medical Record documents immediately after the 12/04/21 incident, staff placed R1 on 1:1 supervision for 24 hours per the instruction of V1. R1's Plan of Care, on 12/08/21, still failed to identify that R1 was touching female residents, no plan was developed to ensure ongoing monitoring of R1's behavior or how protect female residents. On 12/07/21 at 3:15 pm, V1 (Administrator) stated she was unable to locate any documentation to suggest the previous Administrator conducted an investigation into the sexually inappropriate incidents R1 initiated with female residents on 11/13/21 and 11/14/21, and it was unknown exactly which residents were affected/involved. At that same time, V2 (Director of Nursing) stated there was no plan put into place to ensure R1 was monitored and/or supervised after the 11/13/21 and 11/14/21 incidents. V2 stated the previous Administrator (V10) told Staff in their daily meetings that "everything was taken care of" in regards to R1's sexual advances to female residents, and confirmed that there had been no changes made to R1's Plan of Care addressing interventions to protect female residents from his increasing sexual behaviors. On 12/08/21 at 3:10 pm, V1 (Administrator) stated she was still reaching out to staff in attempt to obtain further details regarding which	S9999		

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S9999	Continued From page 11 residents were affected by R1's sexually inappropriate behaviors on 11/13/14 and 11/14/21. V1 stated there is no evidence that an investigation was even initiated or reported to the State Agency by V10, or that staff identified in R1's Plan of Care that his sexually inappropriate comments had now progressed to inappropriately touching female residents. A Resident Census Report, dated 12/06/21, documents 41 female residents (R2 - R42) currently reside in the facility (B)	S9999		