STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

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S 000	Initial Comments Investigation of Facility Reported Incident of September 22, 2022/IL151902	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3210t) 300.3240b) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to protect 3 female residents from being sexually abused by a male resident. The facility also failed to ensure that staff report incidents of resident-to-resident sexual abuse to the Administrator or Abuse Prevention Coordinator. This failure resulted in R4 inappropriately touching R1 on 9/22/22, R2 on 9/17/22 and R3 on 9/21/22. This applies to 3 of 3 residents (R1, R2 and R3) reviewed for sexual abuse in a sample of 4. As a result, R1, R2, and R3 cognitive impaired residents would have suffered psychosocial harm by the reasonable person concept. The findings include: 1. The facility policy entitled SG ANE and Investigations _ MW last revised on 3/27/21 states, "Sexual abuse is non-consensual sexual conduct of any type with a resident. All allegations of abuse, neglect, mistreatment, exploitation of residents' funds or property are to be reported immediately to the Administrator and according to Federal and State Regulations." The Incident Report dated 9/22/22 states, "On 9/22/222 at around 10:20 AM, the Administrator was alerted to an allegation of Abuse. (R4) was noted attempting to fondle another resident (R1)..." A written statement dated 9/22/22 by V3 (Certified Nurse Assistant/CNA) states, "As I was picking up room trays, I saw (R4) in the TV room with his hands in (R1's) pants. I quickly told him to stop. He ignored me and I removed him from the TV room. I then fixed (R1's) clothing because he had her shirt pulled up..."	S9999		

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S9999	Continued From page 2 On 10/14/22 V2 (Interim Director of Nursing) stated, "(R4) had no prior incidents, in fact the family was shocked when we called them and told them what had happened. (R4) is confused and has a BIMS (Basic Interview for Mental Status) score of about 5 or 6 (cognitively impaired). When the CNA found him, he had his hands in the (R1's) pants. They were both out in the day room, very visible to everyone. They were separated immediately." On 10/14/22 at 1:10PM V8 (R4's Psychiatrist) stated, "Since that one episode I don't believe he has had any other issues. I would say it is just his Dementia with behaviors. The Prozac seems to be working really well for him." R4's Admission Record shows that R4 is a male resident with diagnoses including Chronic Obstructive Pulmonary Disease and Dementia. R4's Minimum Data Set Assessment dated 10/11/22 shows that R4 has Severe Cognitive Impairment. R1's Admission Record shows that R1 is a female resident with diagnoses including Dementia with Behavioral Disturbance, Cerebrovascular Disease and Aphasia. R1's Minimum Data Set Assessment dated 8/10/22 shows that R1 has Severe Cognitive Impairment. The facility Incident Audit Report dated 9/23/22 states, "Male resident was observed inappropriately touching resident in the TV room. Contributing Factors: Both residents confused with Dementia. BIMS for both residents is coded as severely impaired..."	S9999		

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2. On 10/14/22 at 11:47 AM, V1 (Administrator) stated, "I am going to be perfectly honest with you. When we interviewed the other CNAs about this incident (with R1) , we found out that (R4) had been sexually inappropriate with (R2 and R3) also."

R2's Incident Audit Report dated 9/22/22 states, "CNA reported to DON that she witnessed (R4)inappropriately touching (R2) in the TV room."

V4's (CNA)Employee Counseling Form dated 9/22/22 states, "You reported resident (R4) was inappropriately touching another resident (R2) on 9/17/22. You reported this to your nurse, but you must report allegation of unwanted touching or sexual abuse to the abuse coordinator (the Director of Nursing/DON).

An undated written statement by V4 (CNA) states, "On September 17, 2022, I saw (R4) touching (R2) inappropriately. I removed him and notified the nurse. As I went back to check on (R2), (R4) was back trying to talk to her. I asked him to please go somewhere else and leave her. He kept trying to find his way back to her multiple times and I kept blocking him. The nurse was notified the whole time." In a different handwriting this same form shows a statement of, "DON re-interviewed (V4-CNA) to clarify the above statement. (V4) stated (R4) touched (R2) on the breast over her clothing. "

On 10/14/22 at 2:00PM V4 stated, "From what I think I saw, (R4) was in the TV area and he was next to (R2). From far away it looked like he was touching her breast. I called his name and he

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looked at me but then it looked like he was reaching toward her breast. I told the nurse (V5 Registered Nurse/RN). I have never seen him touch anyone else before. Most of the time he is in the TV area. He goes to the little book corner, and he sits and reads. His speech is not very easy to understand, and I have never heard him say anything about wanting to have sex. "

A written statement by V5 (RN) dated 9/22/22 states, "On 9/17/22 V4 reported to me that (R4) kept trying to touch (R2). I was not notified that (R4) touched any body part of (R2). I was made aware that he was trying to get close to (R2). I also noted myself that (R4) was trying to touch (R2) by reaching out and approaching her. I did not see (R4) touch any body part of (R2)."

On 10/14/22 at 1:45 PM V5 stated, "I was told (R4) was trying to touch (R2), not that he had actually touched her. He is Aphasic and confused. (V4) reported to me that (R4) was trying to touch (R2). She didn't say anything about (R4) physically touching (R2). The CNA didn't say where he was trying to touch. I assessed the situation in the TV area. I didn't remove him from the area. I have never seen him do anything. I had no issues with him. I did an assessment on (R2) just to be sure, but she is confused. I don't think she was even aware that anything happened. "

V5's (RN) Employee Counseling Form dated 9/22/22 states, "It was reported by CNA (V4) she reported to you as assigned nurse resident (R4) was inappropriate with resident (R2) at this time residents should have been separated and abuse coordinator notified immediately."

R2's Admission Record shows that R2 is a female

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FORM APPROVED
Illinois Department of Public Health

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S9999	Continued From page 5 resident with diagnoses including Parkinson's Disease and Dementia. R2's Minimum Data Set Assessment dated 7/27/22 shows that R2 has Severe Cognitive Impairment 3. R3's Incident Audit Report dated 9/22/22 states, "CNA reported to DON that she witnessed resident (R4) inappropriately touching (R3) in the TV room." V6's (CNA) Employee Counseling Form dated 9/22/22 states, "You reported you saw (R4) touch (R3's) breast on 9/21/22. Should have reported observation of residents on 9/21/22 immediately to the abuse coordinator." A written statement by V6 (CNA) dated 9/22/22 states, "On September 21st, V7(RN) asked me to take (R4) away from a (R3) because he was touching her inappropriately. I saw him touching her breast." On 10/14/22 at 12:55 PM V6 stated, "I was far away and when the nurse asked me to separate them, and I went toward (R4), he kind of pulled back away from (R3). I know I said (R4) was touching her beast but now I am not sure if that is what I saw. I moved (R4) away from (R3) and I moved him to his room. He likes to read, and he likes puzzles so when he went to his room. He grabbed his book and started reading. I have never seen him touch anyone else. Nothing like this before that." An undated written statement by V7 (RN) states, "On September 21st I noted (R4) touch (R3's) hands, they were sitting in the TV room, and I had	S9999		

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(V6) remove (R4) and take him to his room. I have never witnessed inappropriate behavior, but I didn't want him to continue to touch her, so I separated them. "

On 10/14/22 at 12:35 PM V7 stated, "(R4) was touching (R3's) hands. They were both in wheelchairs in the TV room. His room used to be (XXX). I was on the phone, so I asked (V6) to please separate them. I think she put (R4) at the nurse's station. I didn't do anything after that. He wasn't just touching her hand; he was more like holding her hand and I didn't like the way it looked. (R3's) daughter is very involved with her care and is here almost every day and I knew she would not like that if she saw it. (R3) is non-verbal and she really didn't react to what (R4) was doing."

V7's (RN) Employee Counseling Form dated 9/22/22 states, "It was reported by CNA (V6) she stated nurse asked her to separate (R4) from (R3) because he was touching her inappropriately. CNA (V6) reported she saw (R4) touching (R3's) breast. At this time abuse coordinator should have been alerted to allegations of sexual abuse."

R3's Admission Record shows that R3 is a female resident with diagnoses including Hemiplegia and Hemiparesis Affecting Left Dominant Side, Aphasia and Vascular Dementia.

R3's Minimum Data Set Assessment dated 9/28/22 shows that R3 has severe Cognitive Impairment.

"B"