STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011571	A. BUILDING: _____ B. WING _____	C 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE HC OF PAXTON ON PELLS	1001 EAST PELLS STREET PAXTON, IL 60957

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S 000	Initial Comments Investigation of Facility Reported Incident of 1/25/22 /IL#143066	S 000		
S9999	Final Observations Investigation of Facility Reported Incident of 1/25/22 /IL#143066 STATEMENT OF LICENSURE VIOLATIONS: 3001210b) 300.3240a) 300.3240c) 300.3240f) 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 care needs of the resident. 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) Section 300.3240 Abuse and Neglect 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)	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect f) A facility that becomes aware of photographing or recording of a resident, without the resident's consent or knowledge, or any other abuse, shall comply with subsections (a) through (e) of this Section. These regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure R2 was not subject to sexual abuse by R1. This failure resulted in R2 having increased anxiety and feelings of shame. R1 and R2 are two of three residents reviewed for abuse in the sample of four. Findings include: R2's Face Sheet dated 2/1/22 documents R2 is diagnosed with Multiple Sclerosis, Obesity, Bipolar Disorder, Depression, and Anxiety. R2's Minimum Data Set dated 12/30/21 documents R2 is cognitively intact and requires extensive assist for bed mobility and locomotion and is totally dependent upon staff for transfers. R2 uses a wheelchair for mobility assistance. R2's Care Plan dated 1/30/22 documents R2 is at risk for changes in psychosocial well-being related to recent episodes with another resident (R1). R1's Face Sheet dated 2/1/22 documents R1 is diagnosed with Cerebral Infarction, Left side Hemiplegia and Hemiparesis, Alcohol Abuse, and Dementia with Behaviors. R1's Minimum Data Set dated 12/31/21	S9999		

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documents R1 requires supervision while using his wheelchair for mobility/locomotion.

R1's Care Plan dated 1/26/22 documents R1 has exhibited the behavior of displaying inappropriate sexual behavior towards others.

The Final Incident Report documents on 1/25/22 R2 stated R1 was in the doorway of R2's room masturbating. The incident report documents both R1 and R2 are Alert and Orientated residents.

On 2/1/22 at 1:55 PM R2 stated R1 lived across the hall from her and would frequently be at her doorway multiple times per day. R2 stated R1 would often look at her (R2) while fondling himself (R1) with his hand inside his (R1) pants and on two specific occasions R1 began masturbating with his hand inside his pants. R2 stated R1 frequently opened her (R2) door when it was closed without permission and would sometimes make his (R1) way into her (R2)room uninvited to give her (R2) things (about 10 times). R2 stated staff were aware because R2 often had to call for them to remove R1 from her doorway or they would hear R2 yelling at R1 and come to help. R2 stated she would tell him (R1) "to get the f*** (expletive) out of here." R2 stated, "when (R1) was masturbating while looking at me it made me feel ashamed and dirty, even though I know I didn't do anything wrong." R2 stated R1 invaded her privacy and made her feel very uncomfortable. R2 stated R1's sexual behavior towards her increased her anxiety significantly and it bothered her that R1 seemingly could come into her room uninvited anytime he(R1) wanted to. (R2 then began to cry) R2 stated on 1/26/22 R1 came to sit at her table in the dining room and his presence made her so uncomfortable that she

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couldn't take it anymore and she had to ask to leave the dining room in order to finish her meal. R2 stated she went back to her room after lunch and cried. Later that day (1/26/22) R2 found out R1 was leaving the facility and she hasn't seen him since. R2 stated she feels relieved now that R1 is gone.

On 2/1/22 at 12:00 PM V10 Licensed Practical Nurse stated over the last month she has observed R1 a few times, pleasuring himself in public areas in the facility (dining room, nurses station, hallway), make sexual comments to staff, and sitting at R2's door with his hands down inside his pants, pleasuring himself. R2 would put her call light on and ask us to move R1 from her doorway. V10 LPN confirmed she does consider R1's sexual behavior abuse when it comes to R2 because R2 cannot get up and leave, shut her door, or remove herself from the situation without staff assistance.

On 2/1/22 at 12:16 PM V7 Licensed Practical Nurse stated R1 would often sit at R2's doorway and would open R2's door if it was closed. V7 stated she was providing care for R2 once and R1 opened the door. Luckily they had R2 covered up and so she was not exposed. V7 stated R1 kept doing it though no matter how many times the staff would tell him to stop.

On 2/1/22 at 12:30 PM V4 Certified Nurses Assistant stated both R1 and R2 are alert and orientated residents. V4 stated within the last month or so R1 has been sitting in front of R2's door and opening her door and other resident's doors when they are closed. V4 stated R1 does sit in front of R2's door with his hands down his pants and would masturbate. V4 stated at first R1 was easily redirected but after R2 reported an

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incident on 1/25/22 and after the staff began keeping a close eye on R1, he became much more aggressive with his response to redirection. R1 would move around the halls and then stop and put his hand down his pants. R1 would masturbate in front of R2's doorway. On 1/26/22 R1 did this five or six times. When redirected he would cuss and spit at staff and then 20-30 minutes he would be doing it again. V4 stated she never recognized R1's actions as abusive before now.

On 2/1/22 at 1:03 PM V11 Certified Nurses Assistant stated she has observed R1 sitting in front of resident's doors and opening doors to resident's rooms including R2. V11 stated she has observed R1 with his hands down his pants touching himself while sitting at the nurses' station in the view of staff and other residents. V11 stated she has observed R1 open R2's door when the staff were providing care for R2. R1 had to be redirected.

On 2/1/22 at 1:05 PM V5 Licensed Practical Nurse stated when he came on shift on 1/26/22 he was told in report that R1 was to be watched closely and redirected away from other resident's rooms and doorways. We were supposed to watch R1 closely because the day before he had been masturbating in front of R2's doorway. During my shift on 1/26/22 R1 was repetitively going to R2's door and was being very combative when staff were attempting to redirect him. R1 began spitting, cursing, and yelling at staff whenever redirected. I was informed by V4 Certified Nursing Assistant that R1 was observed in front of R2's door with his hands down his pants in a sexually obscene manner. I informed V1 Administrator about this and about the increase in R1's sexual behavior and angry

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S9999	Continued From page 5 outbursts. On 2/1/22 at 2:06 PM V13 Certified Nurses Assistant stated she observed R1 in the hallway with his hands in his pants, pleasuring himself on multiple occasions. V13 stated R1 would do it at least twice every time she worked which was on average five days per week. R1 also opened the door to enter into R2's room when the door was closed for privacy and care. R2 mentioned at that time that R1 would often come into her room uninvited. On 2/1/22 at 2:45 PM V3 Social Service Director confirmed R2 is a vulnerable resident who cannot move on her own and who requires staff assistance for transfers and mobility. V3 confirmed if staff were aware of R1 masturbating or feeling himself sexually outside of R2's door they should have reported it to V1 Administrator so he could investigate it. V3 confirmed that prior to R2's allegation on 1/25/22, staff had never reported R1 masturbating in front of R2. V3 confirmed R2 was upset about the situation and was relieved that R1 was no longer in the facility. V3 stated R2 seemed to be doing better than she was a few days prior. The facility's Abuse and Prevention Program dated February 2021 documents the facility affirms the rights of residents to be free from abuse, neglect, or misappropriation. The same document defines abuse as any physical or mental injury or sexual assault inflicted upon a resident other than accidental means. Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. (B)	S9999		

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