STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 06/03/2022

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FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

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S 000	Initial Comments Incident Report Investigation to Incident of April 21, 2022/IL147396	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 300.3240a) 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 300.1210 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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S9999	Continued From page 1 care needs of the resident. 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 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) These regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure a resident (R3) was free from sexual abuse and the facility failed to ensure a resident (R1) was free from verbal abuse for 2 of 6 residents reviewed for abuse in the sample of 6. The findings include: 1. R2's current care plan showed R2 was severely cognitively impaired related to his diagnosis of dementia. R2's care plan also showed R2 had behaviors of wandering around the unit without clothes on, grabbing the "private areas" of male staff, and making sexually inappropriate comments. The care plan showed R2 did not have the cognitive ability to understand the behaviors he exhibited were inappropriate. R2's progress note dated March 17, 2022	S9999		

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S9999	Continued From page 2	S9999		

showed R2 was admitted to the health care unit of the facility. It showed R2 was confused and had a history of "wandering and behaviors".
R2's progress note dated March 19, 2022 showed R2 was "found standing in the doorway of his room without any pants on" by staff.
R2's progress note dated March 20, 2022 at 1:02 PM showed, "Resident was found standing in door way without pants on ...Resident has been found standing in doorway disrobed multiple times throughout the day. Nursing staff has also found resident roaming in the hallway disrobed, attempting to wander into other resident's rooms ..." The note showed R2 became agitated when redirected by staff.
R2's progress note dated March 20, 2022 at 9:19 PM, showed. "Resident has been making sexual advances towards male staff members, both physically and verbally throughout the night. Nursing staff has had to redirect resident back into his room multiple times, due to resident attempting to wander hallways disrobed ..."

On May 31, 2022 at 11:53 AM, V9 CNA was interviewed about R2's behaviors on March 20, 2022. V9 stated, "I walked into his room that day and (R2) was standing there with no pants or underwear on. I bent over to help put underwear on (R2) and he tried to hug me naked and then grabbed my butt. I backed away and tried to redirect him. I told the nurse about it."

R2's progress note dated March 22, 2022 at 3:08 PM showed R2 was found by staff standing naked in a doorway, holding wet underwear.
R2's progress note dated March 22, 2022 at 4:43 PM showed R2 "walked to stand in front of a male resident, unzipped his pants, and pulled out his penis." The note showed no documentation that this incident was reported to V11 (R2's

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S9999	Continued From page 3 Physician) or V12 (R2's Psychiatric Nurse Practitioner/NP) at the time this incident occurred. R2's progress note dated March 22, 2022 at 5:04 PM showed, "Resident seen coming out of male resident room across the hall from his room in just his underwear. Started toward his room and then turned and re-entered other room ..." The note showed no documentation that this incident was reported to V11 (R2's Physician) or V12 (R2's Psychiatric Nurse Practitioner/NP) at the time this incident occurred. R2's progress note dated March 22, 2022 at 7:01 PM showed R2 was found outside of his room with no clothes per facility staff. R2's progress note dated March 23, 2022 at 9:16 PM showed R2 "tried to grab CNA's "privates" and said "I want it. Come to bed with me. Let me have it." The note showed no documentation that this incident was reported to V11 (R2's Physician) or V12 (R2's Psychiatric Nurse Practitioner/NP) at the time this incident occurred. R2's progress note dated March 25, 2022 showed R2 was observed by facility staff "asking a male staff member if he "would like to get together later ..." R2's progress note dated April 12, 2022 showed R2 Director of Nursing (DON) was notified of an allegation of sexual behavior that R2 had exhibited towards another resident. The note showed V11 (R2's Physician) or V12 (R2's Psychiatric Nurse Practitioner/NP) were notified of the incident. R2 was sent to a local hospital for an evaluation. The facility's sexual abuse allegation report dated April 12, 2022 showed V7 Certified Nursing Assistant (CNA) witnessed R2 place his left hand down the front of (inside of) R3's pants. V7 CNA intervened and was able to remove R2's hand away from R3.	S9999		

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S9999	Continued From page 4	S9999		

On May 31, 2022 at 9:30 AM, V7 CNA stated on April 12, 2022, "(R3) was seated in her wheelchair in the main sitting area by the nurse's station. (R2) was seated next to (R3) in a recliner. I watched (R2) take his left hand and put it down the front of (R3's) pants. I am not sure if he got inside her incontinence brief. I just know his hand was inside her pants. I immediately got up and walked towards them. I kept saying, "No, no!" (R2) finally removed his hand from (R3's) pants once I got up in front of them. They were immediately separated. (R2) said nothing about what had happened. (R3) was wiggling around in her wheelchair. She is not really verbal."

On May 31, 2022 at 11:15 AM, V8 Licensed Practical Nurse (LPN)/Third Floor Nurse Manager stated, "(R2) had many sexual behaviors prior to the incident with (R3) on April 12, 2022. He would walk around naked, he tried to pull his penis out, and he made sexual comments towards male staff. I am not sure if (V11 R2's Physician) was notified of all of his behaviors. We just tried to watch him closely."

On May 31, 2022 at 12:00 PM, V10 Registered Nurse stated, "I took care of him on March 22, 2022. (R2) walked up to another male resident, unzipped his pants, and pulled out his penis. His penis was actually out of his pants. I told him to put it away and he did ...I did not inform his physician of the incident but I did notify (V2 DON). I was just told to watch him closely. He was not a 1:1 (1 staff member assigned to R2) care at that time."

On May 31, 2022 at 12:50 PM, V2 DON stated, "I don't recall informing (V11 R2's Physician) or (V12 R2's Psychiatric Nurse Practitioner/NP) of

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S9999	Continued From page 5 (R2) pulling out his penis in front of another resident on March 22, 2022. I know I told them about the incident (from 3/22/22) after the incident occurred on April 12, 2022. (V11 and V12) were aware of (R2's) sexual behaviors but he had never actually touched anyone on March 22, 2022. We were just working on trying to adjust (R2's) medications to help control his behaviors ..." On June 1, 2022 at 10:19 AM, V2 stated she felt the behaviors R2 exhibited in March 2022 which included R2 disrobing and exposing his penis were related to R2's incontinence issues and his diagnosis of dementia. On May 31, 2022 at 12:20 PM, V11 (R2's Physician) stated, "(R2) has dementia and disinhibition syndrome where he can't recognize his wrong doing and can't control his behaviors. I don't recall being notified of him pulling out his penis on March 22 or him grabbing the groin of facility staff on March 23, 2022. If I had been notified, it would be documented in a note. If I had been notified by staff, I would have tried to handle the behaviors internally by making him 1:1 care and keeping him in his room. If that didn't work, I would have ordered him to be sent to the hospital for an evaluation." On June 1, 2022 at 10:22 AM, V11 (R2's Physician) again stated that he "doesn't recall" being notified of R2 pulling out his penis on March 22 or him grabbing the groin of facility staff on March 23, 2022. On May 31, 2022 at 1:12 PM, V12 (R2's Psychiatric Nurse Practitioner/NP) stated she "didn't recall facility staff" ever calling her about him pulling out his penis on March 22 or him grabbing the groin of facility staff on March 23, 2022.	S9999		

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S9999	Continued From page 6	S9999		

R3's current care plan showed R3 was not ambulatory and was placed in a high back wheelchair when not in bed. The care plan showed R3 was severely cognitively impaired due to her diagnosis of dementia.
On May 31, 2022 at 1:55 PM, V13 (Daughter of R3) stated, "(R3) is really nonverbal due to her dementia. She has really gone downhill mentally over the last five months. The facility did inform me of the incident that occurred in April (2022). In her right mind, my mom would have never allowed that to happen. She would be so mad. She'd be mortified. She would have slapped him."

2) R1's current care plan showed R1 was severely cognitively impaired related to her diagnoses of dementia and Alzheimer's disease. It showed R1 exhibited physical and verbal behaviors towards staff.

On May 31, 2022 at 8:40 AM, R1 was seated in a high back wheelchair by the second floor nurse's station. When this surveyor asked R1 about the incident on April 12, 2022, R1 looked confused and said, "I'm fine. What are you talking about? Leave me alone!"

On May 31, 2022 at 9:57 AM, V5 CNA stated, "On that day (4/12/22), I was trying to get (R1) up out of bed and she kept hitting me in the face. She looked at me and said "You shut your f .....g mouth." I then responded, "No, you shut your f .....g mouth". It just slipped out I know it was wrong because it was verbal abuse ..."

On May 31, 2022 at 10:10 AM, V2 DON stated, "(V5 CNA) confessed to telling (R1) to shut her

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S9999	Continued From page 7 f.....g mouth. (V5) was terminated immediately. That is verbal abuse ..." The facility's abuse policy (undated) showed, "It is the policy of the facility to maintain an environment where residents are free from abuse, neglect, exploitation, and misappropriation of resident property ..." The policy defines sexual abuse as "non-consensual sexual contact of any type with a resident. Generally sexual contact is nonconsensual if the resident either: Appears to want the contact to occur, but lacks the cognitive ability to consent; or does not want the contact to occur ..." The policy showed, "Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability ..." (B)	S9999		