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
	IL6013361	A. BUILDING: ______ B. WING ______	C 01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA LAGRANGE	4735 WILLOW SPRINGS ROAD LA GRANGE, IL 60525

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S 000	Initial Comments Complaint Investigation 22710194/IL154610	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3210 t) 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 care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to protect a resident's right to be from sexual abuse by another resident.

This failure resulted in R1 experiencing sexual abuse at the facility when R2 put his hand underneath R1's clothing and touched her breast area. R1's medical diagnosis makes assessing the effects of sexual abuse difficult. A reasonable person would not want to be touched in the breast area without consent.

This applies to 1 of 3 residents (R1) reviewed for sexual abuse in the sample of 4.

The findings include:

On December 28, 2022 at 1:30 PM, R1 was sitting in a high-back wheelchair near the doors of the dining room, and close to the nurse's station. R1 was fully dressed and seated next to another resident. R1 was not able to answer questions due to her cognitive status.

The EMR (Electronic Medical Record) shows R1 is a 78-year-old female resident, who was admitted to the facility on May 19, 2022. R1 has multiple diagnoses including metabolic encephalopathy, protein-calorie malnutrition, dementia, and hypertension.

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R1's MDS (Minimum Data Set), dated October 12, 2022, shows R1 has severe cognitive impairment, is totally dependent on facility staff for locomotion, and requires extensive assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of urine and frequently incontinent of stool. R1's MDS continues to show R1 has unclear speech, is rarely/never understood, and rarely/never understands verbal content of others.

On December 23, 2022 at 6:28 PM, V6 (RN-Registered Nurse) documented, "Two staff members reported [R1] being touched inappropriately by another resident. Completed head to toe assessment with nothing noted. MD (Medical Doctor), POA (Power of Attorney) and Administrator made aware. Full investigation to follow."

The facility's Abuse Report Initial Form, dated December 23, 2022 at 7:30 PM shows:
"Type of Abuse: Sexual
Date and time when staff became aware of the incident: 12/23/2022 6:30 PM
Alleged Victim: [R1]
Alleged Perpetrator: [R2]
Who made the allegation: [V3] (CNA-Certified Nursing Assistant)
What was the reported allegation of abuse: On December 23, 2022 around 6:37 PM, [V1] (Administrator) was alerted by CNA [V3] that the resident, [R2] appeared to have his hand underneath the blouse of [R1], another resident. [V3] separated the residents immediately. Head-to-toe assessment completed on [R1], with no concerns. MDs and POAs made aware. MD for [R2] does not want resident sent out for psychiatric evaluation. [R2] is being moved to [another room]. [Local police department] came

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S9999	Continued From page 3 and interviewed both residents and the family of [R1]. There are no concerns at this time. Full investigation to follow." The EMR shows R2 is an 86-year-old gentleman, who was admitted to the facility on December 16, 2022 and discharged to home on December 24, 2022. R2 had multiple diagnoses including, low back pain, abnormal gait and mobility, heart disease, anxiety disorder, hypertension, atrial fibrillation, chronic kidney disease, unsteadiness on feet, history of falling, Alzheimer's disease, diabetes, and depression. On December 19, 2022 at 5:00 PM, V 14 (Physician) documented: "Initial H&P (History and Physical) ...Physical Exam: Neuro: AAO (Awake, Alert and Oriented) times 3 (Person, Place, Time)." R2's MDS, dated December 23, 2022, shows R2 had moderate cognitive impairment, required supervision with eating, and extensive assistance with all other ADLs. R2 was always continent of stool and occasionally incontinent of urine. R2's MDS continues to show R2 had clear speech, was able to make himself understood and was able to understand verbal content of others. On December 27, 2022 at 3:40 PM, V13 (Police Officer) said, "We did make contact with the staff and residents (R1 and R2). After our interviews, we believe [R2] acted with intent and knew what he was doing. He stuck his arm under [R1's] shirt and was squeezing her breast area." On December 28, 2022 at 12:12 PM, V3 (CNA) said, "I had noticed when I came out of a room after doing patient care that [R2] was sitting over by [R1]. She (R1) was sitting by the nurse's	S9999		

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station. She usually sits by the nurse's station. She is a fall risk and tries to get up a lot so we can keep an eye on her when she is there. One of the nurses was out of the facility on a dinner break, and the other nurse was in the restroom. No other staff were around. I tiptoed over to [R1] and [R2] because [R2] was so close to [R1]. When I got close, I saw [R2] was holding [R1's] right hand with his right hand, and he had his left hand under her shirt in the front. When I asked him why his hand was under her shirt, his eyes got big. When he saw that I was there, he brought his hand out from under her shirt. I told him to go to his room and he followed my instructions. I worked a lot that week and know both residents well. [R1] would not be able to tell anyone what happened to her because she is so confused. I was surprised by the situation. I have worked here since 2015 and never seen anything like it."

On December 29, 2022 at 10:27 AM, V5 (RN-Registered Nurse) said, "I am an agency nurse. I was assigned to care for [R2] on December 23. I left the facility for about ten minutes to get food. I agreed to stay over into the next shift to pass medications. I did not bring food with me, so I ran to the store to get some food. When I returned, the other nurse and CNA told me there was an incident with [R1] and [R2]. I did not actually witness the incident. I always ask the residents their name, birthday, where they are and why they are there. [R2] was able to answer three of the four questions correctly, though I cannot recall which three he answered correctly. He said he understood me."

On December 29, 2022 at 10:40 AM, V6 (RN-Registered Nurse) said, "[R1] was assigned to me that day. I started at 3:00 PM. [R1] was

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sitting in the chair outside of the dining room so we could keep an eye on her, which is pretty standard. I had to use the restroom and the other nurse was on a break off the floor. All of a sudden [V3] (CNA) was banging on the restroom door calling me to come out because [R2] had his hand under [R1's] shirt in the front. I did not actually witness the resident's hand under her shirt because [V3] had stopped the situation before I got there. I don't think [R2] realized [V3] (CNA) saw what he was doing to [R1] when she said something to him. No other staff were around. [R2] was able to follow instructions to go back to his room, and he looked like he was shameful when he got sent back to his room. The fact that he waited until no one was around to touch the other resident, made it seem like he knew what he was doing."

On December 29, 2022 at 2:45 PM, V12 (Physician) said, "I am familiar with the patient (R1). She is alert, there is a language barrier and a history of dementia. She has cognition issues. She would not be able to give consent to hold hands with a male resident or allow him to touch her underneath her clothing. It is not appropriate for anyone who is not related to touch someone in that way."

The facility's Abuse and Neglect policy, effective 10/24/22, shows: "Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and

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S9999	Continued From page 6 investigation. Types of Abuse: ...5. Sexual: Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Even if there is capacity to give consent, consent obtained through intimidation, coercion or fear is considered sexual abuse. Must be reported examples in the SOM (State Operations Manual) includes: Unwanted touching of the breast or perineal area. A resident who fondles or touches a person's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues. ...Sexual activity or fondling where one of the resident's capacity to consent is unknown." (B)	S9999		