STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005169	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEFRONT NURSING & REHAB CTR	7618 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation: 2386720/IL163164 Investigation of Facility Reported Incident of July 17, 2023/IL162278	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.3210t) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by another resident for one (R4) out of three residents reviewed for abuse. This incident resulted in one (R4) resident feeling emotionally and psychologically traumatized. Findings include: R4 is a 32-year-old female with a BIMS (Brief Interview for Mental Status) score (4/20/2023) of 15, which means R4's cognition is intact. Per Face sheet, R4 has diagnosis of major depression. R4's abuse care plan documents: History of sexual abuse.	S9999		

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S9999	Continued From page 2 On 09/19/2023 at 11:32 AM, R4 was inside her room, alert and able to express her thoughts very well. R4 stated a male resident who she has never seen before, touched her arm and shoulder, tried to wake her up and solicited unilateral aggressive sexual contact. R4 stated that she screamed upon realizing the situation that is transpiring. R4 stated that she screamed for help and then V6 (Registered Nurse) came right away. R4 stated that she was traumatized with the incident and unable to sleep because she had past sexual abuse experience. R4 stated that she was afraid that the unidentified male person would come back into her room. On 09/19/2023 at 11:08 AM V3 (Registered Nurse) stated that he is familiar with R2. V3 stated that when R2 was admitted to the facility on 08/08/2023, on (floor different than R4). V3 stated that R2 is a wanderer. V3 stated that on 08/08/2023 R2 went into R4's room (R4's room is located on a different floor than R2) and made aggressive sexual inappropriate comments to R4. V3 stated that he went into R2's room and saw V6 (Registered Nurse) telling R2 that he cannot make inappropriate comments like that, and it was wrong. V3 stated that he talked to R4. V3 stated that R4 told V3 that she was shocked because R2 touched her arm and neck. V3 stated that R4 told him that she was scared and worried and concerned. R4 told V3 that R2 made inappropriate comments. V3 stated that R4 told him that R2 was trying to wake her up. On 09/19/2023 at 02:01 PM, V6 (Registered Nurse) stated that he was working the 3:00 PM to 11:00 PM shift on (R4's floor) on 08/08/2023. V6 stated that R4 is a resident residing (stated floor location). V6 stated that he did not notice R2	S9999		

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S9999	Continued From page 3	S9999		

going into R4's room. V6 stated that R4 told him saying, somebody, who she did not recognize, came in her room, and made an inappropriate/sexual proposal. She said no and he left. V6 stated that he went into R2's room and talked to R2. V6 asked R2 if he went into R4's room. R2 stated he did and was looking for R4 to have sex with her. V6 stated that he called R2 outside his room and R4 identified the resident. V6 stated that R2 admitted that he made inappropriate sexual comments to R4. R4 stated that she was anxious. V6 stated, R4 told him, "I hope he doesn't come down to my floor and into my room again". V6 assured her that R2 won't come down.

R4's progress note by V6 on 08/08/2023 at 07:40 PM documents: Around 7:40pm, resident reported that a male resident came into her room and made an inappropriate verbal proposal to her; she refused.

According to Face sheet, R2 is a 31-year-old male. R1 has medical diagnosis of schizoaffective disorder, homicidal ideation, and bipolar disorder.

On 09/20/2023 at 09:47 AM, V4 (Clinical Manager) stated that at admission we have 72-hour constant observation and monitoring by the interdisciplinary team including social worker, CNA and nurses also watches him. It's our practice to constantly monitor them because we need to understand their behavior.

On 09/20/2023 at 10:37 AM, V5 (Social Services Director) stated the resident must be watched for 72 hours by the social worker. We do not have any behavior interventions in place for R2 to monitor and watch him from going into another

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S9999	Continued From page 4 resident's room. On 09/20/2023 at 2:13 PM, V9 (Nurse Practitioner) stated that schizoaffective is derived of two words. Schizo- meaning prominent psychotic symptoms such as hallucinations, delusions, auditory symptoms, disorganized speech. Affective which means mood such depression, anxiety, and mania. Homicidal Ideation means that there is an intent to harm others. Thought to harm others or specific plan. For example, "I want to hurt the nurse with the knife." Intentional motivation to harm others. Schizoaffective disorder can make you sexual aggressive. It's not always but usually. V9 stated, you can google this information. It is the same. Progress Note by V4 (Clinical Manager) for R2 documents in part: R2 presents as danger to self & others and requires immediate hospitalization due to sexually inappropriate behavior. Resident solicited sexual behavior (to) other resident and touched another resident's arm and neck. Resident is irrational, unpredictable, acting on impulsiveness, and likely to engage in harmful behavior due to impaired judgment, and mental health decompensation. V9 was notified with new order noted and carried out. Resident on monitoring. Progress Note by V3 (Registered Nurse) for R2 on 08/08/2023 documents: R2 had an incident where he said inappropriate comments to another resident on (location of R4's floor). Administrator made aware. Resident is being monitored on (R2's floor location) and has been instructed to avoid this resident and (R4's floor location). (R4's) Floor Nurse made aware. Resident is on continuous monitoring.	S9999		

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S9999	Continued From page 5 R2's baseline care plan does not have behavior interventions related to R2's mental illness diagnosis. Per census, R2 was admitted on the XXX floor and incident happened on the YYYY floor in R4's room. Per incident report, the incident happened inside R4's room located on the YYYY floor. Facility's Abuse Report Final documents in part: R4 did report difficulty sleeping for two nights after the incident. Facility's Abuse Policy (07/14/2023) documents in part: 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. Abuse is the willful infliction of mistreatment, injury, unreasonable confinement, intimidation, or punishment. Abuse assumes to intent harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse. 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 to intimidation, coercion, or fear is considered sexual abuse. "B"	S9999		