STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING _____ B. WING _____	C 05/04/2023

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PIPER CITY REHAB & LIVING CTR	600 MAPLE STREET PIPER CITY, IL 60959

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S 000	Initial Comments Facility Reported Incident of 4/24/23/IL159160	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210d)6) 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. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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 were not met as evidenced by:	S9999		

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S9999	Continued From page 2 A. Based on observation, interview and record review the facility failed to protect the resident's right (R2) to be free from sexual abuse by another resident (R1.) The facility failed to recognize repetitious inappropriate touching as potential sexual abuse and develop and implement interventions to prevent the continued abuse of R2 by R1. These failures resulted in R1 being left with unsupervised access to R2 and R1 repeatedly touching R2's thigh and perineal area over R1's clothing and brief. R1 and R2 are two of 11 residents reviewed for abuse in the sample of 11. Findings include: The facility's Abuse Prevention policy revised 11/28/16, provided by V1, documents residents have the right to be free from abuse and the facility prohibits mistreatment and abuse of residents. Steps taken to prevent mistreatment/abuse include identifying incidents of potential mistreatment/abuse, dementia management, immediate protection of the alleged victim, investigating all allegations, implementing changes to prevent future occurrences, and a process for reporting abuse. During abuse investigations, residents who are alleged perpetrators of mistreatment/abuse of another resident will be removed from contact with the victim resident. The perpetrator resident's condition will be evaluated to determine interventions and placement, considering the safety of both residents involved in the allegation. Care Plan problems, goals, and interventions to reduce chances of mistreatment/abuse. a.1.) The facility's Final Report to IDPH (Illinois Department of Public Health) submitted on	S9999		

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S9999	Continued From page 3 4/28/23 documents the following: On 4/24/23 at 2:30 PM the facility received an allegation of inappropriate sexual touching between R1 and R2. The Certified Nursing Assistant (CNA) V4 entered the activity room and observed R1's left hand down the back of R2's pants, between R2's pants and incontinence brief. R1 patted R2's bottom. R1 and R2 were immediately separated and placed on 15-minute checks for 72 hours. R1 was given one to one by V1 Administrator and V8 Social Services Director and educated on inappropriate touching of R1's peers. R1 reported that R1 did not have R1's hands down R2's pants. R1 admitted to patting R2 on the back of R2's thigh. This report documents the physician was notified on 4/24/23 but does not document a time the physician was notified. This report does not document that V18 (R1's Physician) and V19 (R2's Physician) were both notified of the allegation. V4's written statement dated 4/24/23 documents V4 witnessed R1's left hand down the back of R2's pants. R1's Diagnoses List dated 5/1/23 documents R1 has Alzheimer's Disease and Vascular Dementia. R1's Minimum Data Set (MDS) dated 2/13/23 documents R1 has severe cognitive impairment and had no behaviors during the look back period. R2's Diagnoses List dated 5/1/23, documents R2 has Dementia. R2's MDS dated 3/27/23, documents R2 has short- and long-term memory impairment. R2 is not able to recall current season, location of R2's room, staff names/faces, or that R2 resides in a nursing facility. R2 has severe impairment with daily decision-making ability. R1's Behavior Note dated 4/15/2023 12:44 PM	S9999		

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S9999	Continued From page 4 documents R1 had R1's hand in between another unidentified resident's legs. R1 was redirected, was told that it was inappropriate, and was redirected to R1's room. Within 30 minutes, R1 was touching the resident again. R1 was again provided redirection and education. This note is struck out and documented as "incomplete documentation". R1's Behavior Note dated 4/17/2023 10:06 AM documents R1's hand was on another resident's leg. R1 was educated and redirected. There is no documentation in R1's medical record that this behavior or the incident on 4/24/23 was reported to R1's physician. There is no documentation that interventions were implemented to address R1's behaviors of inappropriate touching of other residents, or that these behaviors were exhibited prior to March 2023. The facility's abuse log beginning 11/5/22 does not document any abuse allegations involving R1 prior to 4/24/23. On 5/1/23 at 9:01 AM R1 stated about a week ago R1 touched "her" (R2) on the outside of (R2's) thigh. R1 stated "they" told R1 not to do that again and that R1 is not allowed to touch other residents. R1 stated (R2) was talking and saying (R2) was attracted to R1. R1 was not sure why R1 touched (R2). R1 did not recall touching R2's buttocks/perineal area or having R1's hands down R2's pants. At 10:13 AM, 3:25 PM, and 3:44 PM R1 was sitting in R1's room. There was no staff in R1's room supervising R1. On 5/1/23 at 10:15 AM attempts were made to interview R2 in R2's room. R2 did not respond to questions. There were no staff present in R2's room, supervising R2.	S9999		

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S9999	Continued From page 5 On 5/1/23 at 8:37 AM V6 Housekeeping Supervisor stated about 2 weeks ago R1 followed R2 down the hall and into R2's room. V6 immediately redirected R1 out of R2's room. On 5/1/23 at 9:29 AM V12 CNA stated V12 has walked in on R1 masturbating in R1's room. This behavior was surprising since R1 has not done anything like that before. On 5/1/23 at 9:39 AM V9 CNA stated lately R1 has been putting R1's hands inside R1's pants while sitting in the hallway. We redirect R1 and take R1 to the bathroom. A few weeks ago, R1 and R2 were in the activity room. R2's hands were covering R2's perineal area and R1's hand was on top of R2's hands. R2 was bouncing up and down and anxious. V9 reported the incident to V13 Licensed Practical Nurse (LPN) and R1/R2 were separated. At 12:43 PM V9 stated V9 did not report this incident to V1, since V13 and V3 Assistant Director of Nursing (ADON) were notified. V9 believes the incident occurred on a weekend when V1 was not at the facility. On 5/1/23 at 9:50 AM V8 Social Services Director (SSD) stated R2 does not really talk, often cries, and wanders a lot. R2 has Dementia and impaired awareness. R2 is severely impaired with decision making ability. V8 confirmed R2 does not have the ability to consent to sexual activity/inappropriate touching. R1 has a Brief Interview for Mental Status (BIMS) score of 6/7. A BIMS of less than 12 is questionable if they can consent to sexual activity. R1's decision making is very poor and R1 has poor safety awareness. R1's cognition varies and some days R1 is more cognitively aware. V8 stated lately R1 has been more up front with R2 and R1 was in the activity	S9999		

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room with R2 (referring to the 4/15/23 and 4/17/23 notes). R1 had R1's hand on R2's thigh and rubbed R2's thigh. V8 stated V8 did not think there was anything inappropriate about R1 touching R2. V8 thought R1 was trying to comfort R2. V8 stated V8 separated R1/R2 after an unidentified CNA told V8 that R1 was being too friendly with R2. V8 stated V8 reported the incident to V1. V8 stated V8's note on 4/15/23 was "incorrect" and denied that V8 witnessed R1's hand between R2's legs. V8 stated we encourage the staff to redirect and educate R1, but it is hard to re-educate someone who has a low BIMS score. V8 stated behavioral interventions should be documented on the care plan.

On 5/1/23 at 10:32 AM V5 Housekeeper stated on 4/24/23 around 7:30-8:00 AM V5 went into the activity room to clean. There were no other staff present. R1's hand was on R2's perineal area, rubbing on the outside of R2's pants. R2 appeared scared and was crying. V5 stated V5 had never seen R2 act like that before and V5 reported this incident to unidentified nurses and V9 CNA, because V5 did not think residents are allowed to touch each other like that. V5 stated a few days later R1 followed R2 into R2's room and V5 removed R1 before any physical contact was made. At 12:42 PM V5 stated V5 did not report the incident on 4/24/23 to V1 since V9 said V9 would report the incident to V1.

On 5/1/23 at 10:42 AM V4 CNA stated at approximately 3:40 PM on 4/24/23 V4 walked past the activity room and witnessed R1's left hand down the back of R2's pants. R2 was standing next to R1. R1's hand was between R2's pants and incontinence brief. V4 went in and separated R1/R2. There were no other staff

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present in the activity room. V4 reported the incident to V3 Assistant Director of Nursing (ADON), V14, and V1. R2 was put on 15-minute checks, and V4 was unsure what interventions were implemented for R1.

On 5/1/23 at 1:00 PM V25 CNA stated a few weeks ago V25 assisted R1 with morning cares, and R1 grabbed V25's breast. V25 stated that behavior was unusual and new for R1, and V25 notified V11 Registered Nurse. V25 stated behaviors are documented on report sheets, not in the resident's medical record.

On 5/1/23 at 11:33 AM V3 ADON stated 15-minute checks were implemented for R1 and R2. R1's BIMS score is high enough that R1 understands education, and R1 was educated to notify staff when residents appear upset and not to touch any residents. V3 stated we try to do one on one supervision, but often don't have enough staff so that is why we implement 15-minute checks for 72 hours. Residents with BIMS score of 0-7 do not have the ability to consent to sexual activity. R2 has severe cognitive impairment is not able to consent to sexual activity. V3 stated physician notification is documented in the progress notes.

On 5/1/23 at 11:46 AM V1 stated on 4/24/23 at approximately 2:30 PM V4 walked into the activity room and saw R1's hand down the back of R2's pants, between R2's pants and brief. R1 was brought to V1's office and denied that R1's hand was down R2's pants. R1 said R1 patted the back of R2's thigh while R2 was standing, attempting to get R2 out of the way. V1 stated we educated R1 not to touch residents inappropriately. R1 and R2 were placed on 15-minute checks for 72 hours. At the end of March 2023, the staff reported that R1

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S9999	Continued From page 8 had R1's hand on R2's thigh while sitting in the television room. V1 did not consider that incident to be an allegation of abuse. V1 stated V1 was not aware of any incidents that involved R1's hands on R2's perineal area. At 1:30 PM V1 stated there is not much charted about R1's behaviors on R1's behavior tracking forms. At that time, V8 SSD stated collectively the interdisciplinary team determines the behavior and interventions that are documented on the monthly behavior tracking forms and V8 is responsible for reviewing the behavior tracking. V8 and V1 confirmed there is no documentation of behavior tracking and behavioral interventions to address R1's behaviors directed towards R2, and R1's Care Plan does not address R1's sexual behaviors/inappropriate touching. On 5/1/23 at 12:06 PM V7 (R2's Spouse) stated V7 is the person the facility contacts for R2's change in health and accidents/incidents. V7 stated V7 was not notified of any recent incidents of R2 being inappropriately touched by another resident. If R2 were of sound mind, R2 would have been upset, and would not have let that happen. V7 stated R2 has dementia and R2's mind is "gone". V7 stated, "I hope they watch that resident (R1), I wouldn't want him (R1) to take advantage of her (R2)". (B)	S9999		