STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004188	A. BUILDING: _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES REHAB & HEALTH CARE	310 EADS AVENUE PARIS, IL 61944

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S 000	Initial Comments Facility Reported Incident of 11/18/23/ IL167140	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 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) Based on interview and record review the facility failed to protect the resident's right to be free from sexual abuse by another resident by failing to supervise a resident (R1) with known sexual behaviors from making non-consensual sexual contact with another resident (R2) and failed to protect other vulnerable residents (R4, R5), from inappropriate sexual behaviors by another resident (R1). These failures affect four (R1, R2, R4, R5) of eight residents reviewed for abuse in the sample list of eight residents. These failures resulted in (R1) having unrestricted access to (R2) resulting in (R2) being sexually abused by (R1). Based on V17's (R2's Power of Attorney) statement that R2 would have been angry, upset, sad and would have fought back if R2 did not have Dementia it can be determined that R2 would have experienced psychosocial harm (e.g., embarrassment, humiliation, anxiety) because of the sexual abuse. These failures also resulted in R4 experiencing psychosocial harm as evidenced by V18 (R4's Power of Attorney) stating R4 was withdrawn, feared R1, and had increased anxiety	S9999		

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S9999	Continued From page 2 after being harassed by R1. The Facility Reported incident dated 11/27/23 at 2:30 PM documents on 11/18/23 at 10:00 AM that, "(V3 Housekeeper) noticed that (R1) and (R2) were sitting together very closely in the TV (television) Lounge. (V3) observed (R1's) hand down the front of (R2's) pants." R1's Admission Assessment dated 9/8/23 at 2:40 PM, documents R1 was admitted to the facility on 9/8/23 with diagnoses of Alzheimer's Disease, Seizures, Tremors, Hypertension, Heart Failure, and Psychosis. This assessment documents R1 is alert to person and place. This assessment did not document any behaviors for R1. R1's Behavior Notes document the following: 9/9/2023 at 10:55 AM, written by V5 Licensed Practical Nurse (LPN), "(R1) Attempted to grab staff inappropriately when being taken down to the dining room for lunch time." 9/9/2023 at 10:59 AM, written by V5 LPN, "Staff alerted me resident (R1) had pulled his private parts out et (and) stated, 'come play with this baby.'" 9/10/2023 at 9:04 AM, written by V5 LPN, "(R1) Inappropriateness towards staff before et after breakfast." 9/12/2023 at 3:02 AM, written by V10 LPN, "(R1 continues) to be inappropriate with staff during HS (hour of sleep). Tries to grope staff members while they are at desk charting. Constantly being told, 'No, that's inappropriate et. Let's not be doing that.' (R1) cont. (continues) to have smile on face and cont. to advance towards staff. Redirection unsuccessful." R1's Psychiatry note dated 10/2/23 documents R1 also has the diagnosis of Inappropriate Sexual	S9999		

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S9999	Continued From page 3 Behavior. R1's Care Plan with an initiation date of 9/20/23 does not document interventions for R1's sexual behaviors. R1's Behavior Notes document the following: 10/5/2023 at 11:10 PM, written by V11 RN (Registered Nurse), "(R1) attempted to get in (R4's room) several times. Entered (R4's) room et approached bed 2. (R4) yelled for (R1) to get out. (R1) redirected out of room." 10/6/23 at 4:25 PM, written by V5 LPN, "(R1) Keeps following (R4) into rooms, dining rooms even after (R4) doesn't want him to follow (R4) or be around (R4). 10/6/2023 at 4:27 PM, written by V5 LPN, "(R1) playing with (R4's) hair and (R4) screamed not wanting to be bothered." R1's Alert Note dated 10/7/2023 at 12:24 PM, written by V5 LPN documents, "(R1) went into (R4's) room around 10:40 PM, woke (R4) up by trying to touch (R4), (R4) yelled no and for him to get out. CNA (Certified Nursing Assistant) removed him from the room and asked him to stop, that's a lady's room and to go back to his own room." R1's Behavior Note dated 10/7/2023 at 12:25 PM, written by V5 LPN documents, "(R1) keeps following (R4) around after meals, scaring (R4) and (R4) is yelling out loud. We have asked him to leave (R4) alone, removed him from the area, removed (R4) from the area, he still wheels himself to where (R4) is located." R1's Care Plan with an initiation date of 9/20/23 does not include any new interventions for R1's behaviors towards R4.	S9999		

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S9999	Continued From page 4 R4's Care Plan with an initiation date of 3/22/23 documents R4 has a diagnosis of Dementia and has impaired safety awareness. This care plan also documents that R4 has impaired decision making, and long and short-term memory loss. On 12/11/23 at 6:00 PM (V18) R4's Power of Attorney (POA) stated, "The facility did not tell her about R1 coming into R4's room and touching her leg. V18 stated "They (facility) called me and asked if they could increase her medication due to 'social anxiety.' That would have been right after (R1) came into her room. (R4) was very withdrawn after that. When I would visit (R4), she would hide behind me whenever (R1) came around her. You could tell (R4) was scared of (R1) and now that explains why. I started visiting more often because I thought something was going on. That explains it. (R4) has advanced Dementia. (R4) was married to my dad. (R4) would never allow any other man to touch her in an intimate way. (R4) would be ashamed of something like that happening. It would devastate her. (R1) would come up to (R4) and say, 'there's my girl' and (R4) would try to back away from (R1). (R1) was on her like a magnet. (R1) just couldn't stop trying to be around her." R1's Behavior Note dated 11/15/2023 at 3:26 PM, written by V5 LPN documents, "Trying to touch another (R5's) buttocks as they were walking in front of (R1). (R5) said 'hey stop that,' as he (R1) smiled and rolled away." R1's Behavior Note dated 11/18/2023 at 9:41 AM written by V5 LPN documents, "Trying to follow (R5) and get (R5's) attention, (R5 stated) 'no sir or I will slap you.' (R1) left the area and walked away."	S9999		

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S9999	Continued From page 5 R1's Care Plan with an initiation date of 9/20/23 does not include any new interventions for R1's behaviors towards R5. R5's Care Plan with initiation date of 11/8/23 documents R5 is alert and oriented. On 12/11/23 at 10:50 AM, R5 stated "Oh yes. I remember that clearly. I was standing at the nurse's desk there by the dining room and that man (R1) wheeled up behind me and goosed me right on the bottom. The staff were at the nurse's desk and moved (R1) away. There was another time when (R1) wheeled up to me when I was sitting and eating lunch. I was sitting at my dining room table. The dining room was full of other residents. (R1) came up to me and started grabbing my arm trying to pull me away from the dining room table." R1's Behavior Note dated 11/18/2023 at 10:33 AM written by V5 Licensed Practical Nurse documents, "(R1) was witnessed touching another resident (R2) inappropriately in the dining room/activity room. Escorted (R1) away from other (R2)." The facility's Incident Investigation Form dated 11/18/23 at 10:19 AM, written by V5 LPN documents, "I was alerted by (V3 housekeeper) that (R1) was touching another resident (R2). I went down and saw (R1) with his hand in (R2's) pants and he was rubbing back and forth in her pants. (R2) was just sitting there not doing or saying anything." On 11/30/23 at 11:14 am, V3 Housekeeper stated on the morning of 11/18/23 she was getting ready to clean the activity room and saw R1 standing	S9999		

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S9999	Continued From page 6 really close to R2 and she thought that was strange, so she approached R1 and R2 and observed R1 having his hand down R2's pants. V3 stated she left the activity room and went to the nursing station and reported the incident to V5 LPN. V3 stated V5 came and told R1 that was inappropriate and to remove his hand from R2's pants. On 11/30/23 at 1:37 PM, V5 LPN stated on 11/18/23, V3 came to the front desk and stated R1 was doing something inappropriate to R2. V5 stated R1 had his hand down R2's pants. V5 stated R1's hand was inside R2's brief. R2's Care Plan with an initiation date of 3/29/23 documents R2 is cognitively impaired and requires total assistance for all daily living activities. On 12/11/23 at 12:40 AM, V17 (R2's POA) stated the facility called him and told him about the incident between R1 and R2. V1 stated R2 would be "p*****" (expletive) if she didn't have Dementia. V17 stated R2 would have been upset and sad and ready to get out of the facility. V17 stated R2 would have never consented to R1 doing that to her. V17 stated if R2 knew what was going on R2 would have fought back. On 12/11/23 at 9:10 AM, V1 Administrator in Training stated the facility was aware that R1 had inappropriate sexual behaviors prior to the sexual abuse incident with R2 on 11/18/23. V1 stated R1 had previous incidents with R4 that should have been reported to facility management. V1 stated R1 had attempted to touch R4 and R5 inappropriately prior to the 11/18/23 incident with R2. V1 stated "I was shocked when I read the nurse progress notes and saw that (R1) had been	S9999		

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S9999	Continued From page 7 harassing these other women (R4, R5) prior to (R1's) sexual abuse incident with (R2). We (facility) should have put (R1) on continual monitoring on 10/5/23 when (R1) tried to chase after (R4). We (facility) could have made some kind of medication changes or something. We (facility) didn't do anything about (R1's) behaviors towards other female residents. I did not know about them until I read all those progress notes yesterday (12/10/23). I was just shocked." On 12/11/23 at 10:00 AM, V12 Nurse Practitioner stated, "The facility was aware of R1's inappropriate sexual behavior prior to 11/18/23 when R1 sexually abused R2. V12 stated "This is an unfortunate situation. (R1) has had multiple episodes of inappropriate sexual behavior with other female residents (R2, R4, R5). (R1) should have been put on continual monitoring from the first event on 10/5/23. (R1) has exposed himself to other residents, (R1) has followed other female residents around, touched other female residents inappropriately and nothing was done until 11/18/23 when (R1) put his hands down (R2's) incontinence brief." V12 stated "Our female Dementia residents are the most vulnerable in this facility. I was never informed of the previous two female residents (R4, R5) having been in incidents with (R1). (R1) should have been placed on continual monitoring from the first time that happened with (R4) on 10/5/23. You do not need a physician order to place someone on continual monitoring. The facility should have done that immediately when it happened on 10/5/23 when (R1) was found in (R4's) room touching (R4's) leg when (R4) was in bed. The facility really should have protected their vulnerable female residents better so this incident with (R2) may not have happened."	S9999		

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