

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/02/2024
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NAME OF PROVIDER OR SUPPLIER LOFT REHABILITATION & NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MAIN STREET EUREKA, IL 61530
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S 000	Initial Comments Complaint Investigation: 2424816/174553 Investigation of Facility Reported Incident of 6-2-2024/IL 174897	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
07/24/24

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S9999	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.3210 General</p> <p>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interview the facility failed to protect one resident (R1) from continued sexual abuse from a known sexually aggressive resident (R2) reviewed for abuse in the sample of three.</p> <p>Findings Include:</p> <p>The Facility's "Abuse, Neglect and Exploitation" policy dated 6/8/2020 documents "Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friend or other individuals."</p> <p>The Facility's "Abuse, Neglect and Exploitation" policy dated 6/8/2020 documents "Abuse means the willful infliction injury, unreasonable</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual acted deliberately, not that the individual must have intended to inflict injury or harm."</p> <p>The Facility" Abuse, Neglect and Exploitation "policy dated 6/8/2020 documents that "Sexual abuse is nonconsensual sexual contact of any type with a resident. "</p> <p>On 6/28/24 V1 (Administrator) provided a "State Report" dated 4/1/24 involving R1 and R2 being found with their hands in each other laps." V1 stated "We just had a (Citation) for this, not three months ago. For these same two residents." V1 provided all related information. R2's Medical Record and psychiatric evaluations done after previous incident of R2 sexually abusing R1 on 4/1/24 document diagnosis of depression, posttraumatic stress disorder, and sexually inappropriate behavior.</p> <p>The "State Report" dated 6/2/24 documents that at approximately 6:30 AM V3 (Certified Nurse Aide) witnessed R1's right hand up the shirt of another resident (R2).</p> <p>The written staff interviews from the date of the incident 6/2/24 document that V14 (Certified</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>Nurse Aide) got R2 up and ready on 6/2/24 and left her in her room around 6:20 AM. The statements document that on 6/2/24 around 6:30 AM V3 (Certified Nurse Aide) and V14 (Certified Nurse Aide) both saw R2 wheel herself up to R1 in the lobby and put his hands on her breasts under her shirt. V14 (Certified Nurse Aide) noted that R2 stated "I know I am not supposed to touch him, but it feels so good."</p> <p>R1's Minimum Data Set Assessment (dated 02/28/24) documents a Brief Interview of Mental Status score of 6, indicating severe cognitive impairment.</p> <p>R2's Care Plan last updated on 4/12/24 documents "(R2) has a potential for behavior problem due to personal dynamics, false statements of staff, rejection of cares, crying, repetitive activities, attention seeking behaviors, non-compliance of cares, facility policy, manipulative behaviors towards staff, poor safety awareness, refusal to go to doctor's appointments or counselling, inappropriate behaviors, attempting to touch others."</p> <p>On 6/28/24 at 10:30 AM R2 was in bed, alert and oriented to time, place and situation. R2 was very upset about having a 1:1 care giver states "I don't need a baby sitter." R2 confirmed that she put R1's hand on her breast. Stated "It felt good, he and I are lovers and I don't care what you think." When asked if she thought R1 could consent to being touched or by being made to touch her, R2 stated "I think he (R1) knows that he is a warm blooded man and he wants it. I do believe that." R2 confirmed that she understands that R1 cannot answer any simple yes or no questions for himself yet she stated she felt that "he (R1) would love to feel my breast, I can tell when he (R1)</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>wants to."</p> <p>On 6/29/24 at 9:00AM V2 (Director of Nursing) confirmed that she was aware of issues of R2 being found sexually abusive to R1 in the recent past (4/1/24.) V2 stated she came to work on 6/2/24, she got in verbal report that (R2) was in her room. V2 stated I then carried on about my day as normal until (V9/Certified Nurse Aide) brought R2 to me and explained that she had just witnessed R2 put R1's hands on her breasts. V2 stated "When they (previous staff) said she (R2) was in her room, I assumed they meant in her bed, I didn't check, and she was actually up in her chair, and she can propel herself once up in the chair." V2 confirmed that R1 is in a reclining cushioned wheelchair that he is completely dependent on staff moving for him and that R2 can propel her wheelchair independently once she is up. V2 reported that as of 6/2/24 R2 had been changed to "increase monitoring" after her previous issues with R1. V2 stated that "we had meetings and kind of went over her behaviors and stuff. I don't really remember when she came off of 1:1 and became increased monitoring."</p> <p>On 7/1/24 V1 (Administrator) stated that R2's 1:1 monitoring was discontinued as of 4/4/24 and she was on "increased monitoring" from 4/4/24 until the date of the second incident on 6/2/24.</p> <p>On 6/29/24 at 9:30 AM V1 (Administrator) stated that "increased monitoring is kind of like a step down from being on 1:1, we want to always know where the resident is. For example, if a CNA took a resident that is on "increase monitoring "to an activity, she would stop and tell an activity member that she is leaving the resident there and for that person to keep an eye on her." V1 stated that there would be no documentation of such</p>	S9999		

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S9999	Continued From page 5 monitoring of an increase monitoring resident, and she also could not provide a written policy on "increase monitoring." (B)	S9999		