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S 000	Initial Comments Facility Reported Incident of November 22, 2018/ IL107577 investigation	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental 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)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidence by:

Based on interview and record review the facility failed to supervise a male resident with known sexual aggression to prevent resident from having access to female residents on the dementia unit. This failure resulted in R2 and R3

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S9999	Continued From page 2 experiencing nonconsensual sexual contact by R1. This failure applies to 3 of 3 residents (R1, R2. R3) reviewed for supervision in the sample of 6. The findings include: R1's face sheet dated November 29, 2018 showed R1 was admitted to the facility on June 6, 2018 with a most recent readmission date of September 12, 2018. R1's diagnoses include: dementia in other diseases classified elsewhere with behavioral disturbances, Pick's disease (frontal temporal dementia), delusional disorders, generalized anxiety disorder, pseudo bulbar affect, restlessness and agitation, major depressive disorder, other symptoms and signs involving cognitive functions and awareness and other symptoms and signs involving appearance and behavior. R1's MDS-Minimum Data Set dated September 25, 2018 shows a BIMs-Brief Interview for Mental Status of 14 (cognitively intact). This MDS shows, R1 has other behavioral symptoms not directed towards others on a daily basis and requires supervision and assist of one person for ambulation. R1's Care Plan dated September 18, 2018 showed R1 had a behavior problem and can become verbally agitated and aggressive towards others; sexually inappropriate comments/gestures directed towards others; pacing the halls; makes repetitive statements/questions; has had episodes of physical behavioral symptoms directed towards other residents putting him at risk of abuse related to a diagnosis of frontal lobe	S9999		

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dementia.R1's behavior interventions dated September 18, 2018 include; monitor and record targeted behaviors of pacing, wandering, disrobing, inappropriate verbal communication, violence/aggression towards others. R1 is to be redirected with an activity when displaying behaviors. R1 is to be supervised when he is restless and pacing the halls for entrance into other resident rooms. R1's location is to be monitored every 15 minutes. There are no behavior interventions listed for the October 27, 2018 incident between R1 and R3. There are no documented interventions from September 18, 2018 until the care plan was cancelled on November 23, 2018, after R1's discharge from the facility.

On November 29, 2018 at 10:38 AM, V4 (CNA-Certifed Nursing Assistant) said R1 mainly stayed in his room. He was on 15 minute checks for close monitoring when he would pace the hallways. R1 would wander into other resident rooms. On November 22, 2018 he was on 15 minute checks. V4 said she and V3 were moving a resident chair from their room to the family room. R1 was pacing up and down the hall. V3 and V4 put the chair in the family room out of the sight of R1. R1 was by his room when we went into the family room. V3 went to get a pad for the chair from the linen cart. V3 said she saw R1 in R2's room. R1 was covering up R2. V3 said she asked R1 what he was doing. R1 was taken to his room. V4 was asked to do 1:1 with R1 in his room.

On November 29, 2018 at 9:44 AM, V3 (CNA) stated R1 was on 15 minute checks, "to keep an eye on him." We needed to make sure where he was. He would wander in and out of resident rooms. V3 stated on November 22, 2018 around

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2:00 PM, R1 was unsupervised and was in R2's room. R1 was standing over the bed. As she walked into the room V3 saw R1 place the cover over R2. V3 heard R2 say, "That hurts." V3 took R1 out of the room and asked him what he was doing. R1 stated he was, "Finger f**king her."

On November 29, 2018 at 2:14 PM, V9 (Licensed Practical Nurse) stated R1 preferred to be in room and he would come out for meals. He was independent with his ADLs-Activities of Daily Living. He would have spontaneous laughter which was inappropriate at times. He had repetitive behaviors and would become impatient. He would continually ask until he got what he wanted. He would fixate on things like his chocolate milk. He was easily re directed. He had a hospitalization at a psychiatric hospital after an incident with a male resident. R1 started having increased behaviors and would say inappropriate things to staff like, "you're a fox, nice butt." Approximately three weeks ago he told a visitor she had a nice bottom. He had an incident with R3 in which he was inappropriate. R3 reported R1 poked her and touched her on her right side and right hip and rubbed his hand down her side. We did 15 minute checks. The day of the incident (November 22, 2018) he was having a good day. He was waiting for his wife to bring him dinner. V9 said she was in the nurse's station charting. It was around 2:00 PM. V9 heard the CNA say "what are you doing". When V9 got to the end of the hall, she said to R1 "what are you doing". R1's said "finger f**king" and was smelling his fingers. V9 immediately took R1 to his room and assigned V4 (CNA) to do 1:1's.

On November 29, 2018 at 12:03 PM, V8 (Social Services Director) stated R1 was admitted to the secure unit due to a history of elopement. R1 had

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repetitive behaviors that had changed over his stay. R1 was re directed and able to understand. V8 was asked if R1 had any hospitalizations since his admission. V8 reported R1 was hospitalized twice at a psychiatric hospital following a resident to resident altercation. V8 stated there was an incident when R1 inappropriately touched R3. The facility put 15 minute checks into place and R1 was to sit next to other men in the dining room. V8 stated R1's fixations were becoming more intense and sexual. V8 stated she and the administrator spoke with R1's wife a few days before the incident, about R1 continuing to have sexual behaviors and the facility staff were concerned. We suggested a facility that housed male and female residents separately would be more appropriate for R1. The staff were to make sure R1 was not interacting with female residents by increasing supervision of R1. R1 was on 15 minute checks. She was aware of R1 "escalating sexual fixation". R1 should never have been in R2's room. V8 was asked if R1 was being supervised. V8 said "obviously not if he got into R2's room."

On November 29, 2018 at 3:11 PM, V2 (Director of Nursing) stated R1 started to exhibit sexual behaviors about a month ago. He started with making inappropriate comments to staff, referring to their bottoms. R1 was transferred out that afternoon following the incident of November 22, 2018. R1 was sent out because of his risk to the other residents. V2 said R1 was involved in another incident with a female resident (R3) on October 27, 2018. He inappropriately touched her across her chest and down her leg. We separated them and he was put on 15 minute checks. On November 18, 2018, R1 made an inappropriate comment about a resident. The resident did not hear. The comment was reported

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to the nurse. R1 said, "I want her, can I have her." R1 was re-directed and his 15 minute checks were continued. V2 stated R1 was ambulatory and had a history of going into other resident's rooms. V2 said we should have had him on 1:1 supervision. V2 was asked about the incident when R1 was asking female residents to kiss him. V2 stated he (R1) was to sit next to male residents in the dining room so he couldn't kiss female residents at the table. He was continued on 15 minute checks. V2 stated R1 had become more sexually heightened. "I didn't think he would act on his impulses. When I was told of what happened, I was physically sick."

On November 29, 2018 at 10:17 AM V1 (Administrator) stated R1's dementia changed over time. When he first arrived he had repetitive behaviors. He had a physical altercation with another resident. He was blocking the resident from leaving the room and wanted the other resident to say hi. He kept repeating hi over and over. The other resident hit him with his walker. He had an unwitnessed episode with a female resident (R3) on the couch. The staff went to get him to the table near meal time. When they got him up, R3 said she didn't know who that man was but her husband would get upset. She said his hand was up towards her hip. R1 was on 1:1 and 15 minute checks depending on how he was doing. When he was in his room he was on 15 minute checks. He would pace the hallways and we kept a close eye on him. If he was acting "suspicious" he was on 1:1's. Otherwise he was on 15 minute checks. He was easily re- directed. The day of the incident (November 22, 2018) the two CNAs were moving a chair from the end of the hall to the dining room. R1 was visualized in the hallway near the dining room. The girls put the chair in the dining room. V3 (CNA) went to get

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a pad off the linen cart for the chair. When she got to the linen cart which was outside of R2's room she saw R1 in the room over R2. She asked R1 what he was doing and he made the vulgar comment. The nurse overheard the comment and asked R1 what he said. R1 repeated the vulgar comment.

On November 30, 2018 at 10:20 AM, V7 (R1's Family Member) stated R1 had been at the facility since June 2018. She could no longer care for him at home. He required 24 hour supervision and couldn't be left alone anymore. R1 has temporal frontal dementia and has repetitive behaviors. V7 stated her husband was not supervised. When she would come to visit, she would go into his room and close the door. Hours would go by before anyone would knock on the door. They would say, "Oh, didn't know you were here." V7 stated her husband would walk up and down the hall and look out the end door and check and see if her car was there. V7 stated the nurse practitioner told her due to her husband's disease process, there could be an increase in sexual urges. If R1 started to display increased sexual urges, they could start him on hormonal therapy to help decrease the urges. V7 stated R1 had two hospitalizations one in August and one in September at a psychiatric hospital. R1 had a physical altercation with a male resident. The facility agreed to take him back after they increased his medications. About a month after the second hospitalization, R1 had a rapid decline. He was making a lot of sexual comments to the staff. One incident the facility told me about was he was trying to grab a female resident's waist. R1 told the aides they had nice a**es and he was becoming more sexual. On November 20th, V7 received a phone call from the facility. They suggested he move to another facility

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because he was making more sexual comments. They said he needed to leave for the safety of everyone. V7 called the nurse practitioner and she suggested a smaller unit so there was less stimulation. V5 (Psychiatric Nurse Practitioner) also suggested hormonal therapy for R1. V7 agreed to the hormonal therapy. They gave him the injection the morning of Thanksgiving. Later the same day, V7 went to the facility. The administrator told her, about 30 minutes prior to her arrival, R1 went into another resident's room and placed his hand between her legs. They "shipped him out an hour and a half later."

On November 30, 2018 at 11:46 AM, V5 (Psychiatric Nurse Practitioner) stated she was seeing R1 for his behaviors. He had two hospitalizations at a psychiatric hospital. One in August and one in September. R1 was sent out for increasing behaviors after having physical altercations with a resident. During the August hospitalization his Seroquel was increased to help with re- direction and repetitive behaviors. In September, R1 was diagnosed with pseudobulbar affect disorder. R1 was started on Nudexta. The staff reported he was more easily redirected after the start of the Nudexta and increase in medications. R1 started first having inappropriate sexual behaviors in October. The staff reported he tried to kiss a resident. V5 stated she increased his Zoloft to decrease his sexual urges. A short time later she received a fax from the facility requesting to "try hormonal therapy for increasing sexual desire." V5 asked the staff to clarify why they wanted hormonal therapy, they reported he tried to "kiss a resident." V5 increased his Zoloft and did not feel hormonal therapy was appropriate at the time. In early November, V5 saw R1 and reviewed the nurses notes and asked staff how he was doing, they

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vocalized R1 wanted to have sex with another resident. V5 was told by facility staff R1 was easily redirected. V5 stated the last time she saw R1 was on November 20th, V5 reviewed the nurse's notes and saw he made a comment to a visitor about having a "nice a**." On November 20th, V5 added hormonal monthly injections to decrease sexual urges. V5 stated she was not sure how long it would take for the injections to be therapeutic and R1 was to be supervised. V5 was asked if she was aware of the incident between R1 and the female resident on the couch and his inappropriately touching her chest and sliding his hand down her side on October 27, 2018. V5 stated she was not aware of the incident. Had she known R1 would have been sent out to the psychiatric hospital for a psychiatric evaluation, just like he had been twice before for the physical to physical altercation. R1 should have been on 1:1's until he was sent out.

The facility's Final Incident Report dated November 1, 2018, showed on October 27, 2018 at approximately 4:45 PM, R1 was sitting closely next to R3 on the couch. A Licensed Practical Nurse attempted to try to redirect R1 to another location and he was not listening to her direction. The living room aide, V4 (CNA-Certified Nursing Assistant) then went over and was able to redirect R1 to another spot in the living room. As R1 was walking away, V4 observed R3 making a motion in the air with her hand as if pretending to "smack someone." V4 went over to R3 and asked her if she was okay, and R3 stated, "I don't know who that guy was but he kept touching me (while motioning with her hand rubbing down her arm and across her chest) and poking me (while motioning towards her hips.) R1 was placed on increased behavioral monitoring at the time.

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The facility's Final Incident Report dated November 27, 2018, showed on November 22, 2018 at approximately 2:08 PM, R1 was observed standing in R2's room. V3 (CNA- Certified Nursing Assistant) immediately intervened and asked R1 what he was doing. R2 was observed by V3 as being covered by her bed sheet and in no distress. He (R1) walked out of the room and he made a sexual comment to V3 regarding R2. He (R1) was immediately placed on 1:1 observation per the nurse on duty (V9-LPN-Licensed Practical Nurse) until he was transferred out of the facility.

The facility's Behavioral Assessment, Interventions and Monitoring policy dated January 2017, shows the interdisciplinary team (IDT) will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately to protect the resident and others from harm. The IDT will monitor the progress of individuals with impaired cognition and behaviors. Any resident with behaviors that has been identified that would present a potential danger to either himself or other residents will be place on at least 15 minute checks, unless immediate interventions are needed.

On November 30, 2018 at 1:04 PM V6 (R1's Physician/Medical Director) stated he was R1's physician. V6 stated R1 was having psychotic escalation. R1 should have been on 1:1 supervision follow the first incident. V6 stated maybe he should have ordered the 1:1 supervision. V6 stated due to R1's frontal temporal dementia he would have social and behavioral issues. V6 was asked about the letter he wrote dated November 28, 2018 and which

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S9999	Continued From page 11 female resident he was referring to. V6 stated he was referring to R2. V6's letter dated November 28, 2018, showed R1 was a resident on the dementia unit at the facility. He has a diagnosis of frontal-temporal dementia. During his stay at the facility there has been a gradual developing pattern of inappropriate behavior. There has been a number of minor resident to resident incidents over the past several weeks. There has also been inappropriate sexually explicit comments made to female facility staff. Importantly there has been a recent escalation of sexual 1.comments and actions directed toward female residents on the dementia unit. Most recently an event occurred of molestation of a female resident. The resident was followed by V6 and psychiatric care consulting service. V6 states in the letter, R1's "persistent and refractory behavioral issues pose a distinct and ongoing threat to the other residents on the unit." (A)	S9999		