| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **14E579** | A. BUILDING _____ B. WING _____ | **03/11/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **ROCK RIVER GARDENS** | **3601 SIXTEENTH AVENUE STERLING, IL 61081** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure a resident at risk for abuse was free from sexual abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 27. This failure resulted in R1 responding physically agressively toward (R22). The findings include: R1's medical record showed R1 was a [AGE] year old female. R1's medical record showed R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's acute behavioral healthcare hospital discharge paperwork signed July 1, 2019 showed R1 had a history of [REDACTED]. R1's complete current care plan was reviewed and showed no interventions to protect her against unwanted sexual advances, did not include her history of sexual abuse, and did not include any information regarding her violent reaction to unwanted touching, perceived sexual advances, or sexually inappropriate comments made by male peers. On March 3, 2020 at 8:50 AM, R1 was ambulating independently through the halls. R1 was not making eye contact with the other residents in the hall and walked from one end of the facility to the other at a rapid pace repeatedly. This surveyor approached R1 and requested to speak with her. R1 walked down to her room which was located one room from the end of the hallway. R1 said she was upset by something that had happened. R1 reported that she was sleeping when (R2) came into her room and laid in her bed with her. R1 said R2 began rubbing her back and legs and kissed her on the mouth. R1 said she tried to get him out of her room but R2 would not leave. R1 said she felt uncomfortable and did not want R2 touching her. R1 said R2 told her he was going to sleep next to her and then asked if she has had an orgasm. R1 explained a history of sexual assault to this surveyor and said it makes her feel very uncomfortable when she is touched by other residents. The facility investigations for resident to resident incidents were reviewed and showed three incidents of sexually inappropriate behavior involving R1. 1. The facility's investigation into an incident which occurred on February 21, 2020 between R1 and R2 showed R2 touching and speaking to R1 in a sexually inappropriate manner which resulted in R2's transfer to a behavioral health hospital. The investigation showed R11 and R23 both reported R2 coming into their rooms uninvited in the past. R1's nursing progress note dated February 22, 2020 showed, (R1) has made allegation of inappropriate touching against a male resident .R2's nursing progress note dated February 22, 2020 showed, Allegation of inappropriate touching made against resident by another female resident. (R2) immediately placed on one to one status . R2's nursing progress note dated February 26, 2020 showed R2 was transported to an acute behavioral health hospital. On March 4, 2020 at 11:35 AM, R23 said R2 has come into her room in the past and tried to kiss her. R23 said she told him she did not like him doing this and to stop. On March 4, 2020 at 3:06 PM, V9 CNA (Certified Nursing Assistant) said R2 has been known to go into other resident rooms. V9 said R1 had reported to her that R2 got in her bed and was rubbing her back and kissed her. V9 said R2 has a crush on another female resident and goes into her room uninvited a lot and she will yell at him and tell him to go away. R2's face sheet showed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's complete current care plan was reviewed and showed, (R2) has behaviors of being intrusive to others. He will go into the rooms of other residents, he will obsess over the needs of others and cause conflict.ns. R2's care plan does not identify any sexually inappropriate behaviors or statements and does not include any interventions for sexually inappropriate behaviors. R2's care plan does not address entering other resident's rooms uninvited. R2's nursing progress notes from October 2019 through current showed R2 has been difficult to redirect, intrusive to other residents, and has been entering other resident rooms uninvited multiple times. 2. The facility's investigation into an incident which occurred on February 14, 2020 showed a staff member heard R1 yelling Don't touch me, get away and witnessed R3 trying to kiss R1 and reaching for R1's breasts resulting in R3's transfer to a behavioral health hospital. R1's nursing progress note dated February 14, 2020 showed, (R1) was walking down the hallway when another resident grabbed her inappropriately R3's nursing progress note dated February 14, 2020 showed, (R3) was observed inappropriately touching another female resident . R3's face sheet showed he was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. (No interventions had been added since June 17, 2019) This care plan showed, Resident is known/has history of displaying inappropriate boundaries with staff members. R3's care plan did not address any sexually inappropriate behaviors or inappropriate boundaries toward other residents. 3. The facility's investigation into an incident which occurred between R1 and R22 on September 23, 2019 showed R22 was heard by staff making sexually inappropriate comments to R1 causing her to react violently and resulting in R22 being transferred to a behavioral health hospital. R1's social services progress note dated September 23, 2019 showed, (R1) reported that a male resident (R22) was making inappropriate comments towards her . she told him to stop and leave her alone but the male resident continued .(R1) also said she wanted to speak to someone about her past of 'being touched' . R22's nursing progress note dated September 23, 2019 showed, Resident was heard sexually harassing another resident . they were immediately separated and (R22's) sexual comments and verbally inappropriate comments became worse . for resident and other residents safety the resident was going to need to be sent out for evaluation . R22's social service note dated September 23, 2019 showed, (R22) was upsetting a female resident by saying things to her about sexual contact . (R22) said 'oh you want him to molest you again' . (R22) was sent out for an evaluation . The facility's investigation in to the incident that occurred between R1 and R22 on September 23, 2019 showed a staff member had heard arguing in the hallway. When the staff member responded to the area she overheard R22 making sexually inappropriate comments to R1. R1 began arguing back and in the moment was unable to control herself and made physical contact with R22's chest. During the facility's investigation R1 was interviewed and said she tried to hit R22 in the face. R1 said R22 pushed her and she hit him in the chest. R22 was unable to be calmed down and this incident resulted in R22 being sent to an acute behavioral hospital for evaluation. R22's nursing progress note dated September 23, 2019 showed, Resident was heard sexually harassing another resident. He pushed the other resident too far with his comments and she swung and made contact twice. It was once on his chin/chest and his chest the second time . R22's social services progress note dated September 23, 2019 showed, (R22) was upsetting a female resident (R1) by saying things to her about sexual contact . This is when the female turned around and punched him in the face . R1's social services progress note dated September 23, 2019 showed, (R1) reported that a male resident (R22) was making inappropriate comments towards her . she told him to stop and leave her alone but the male resident continued and (R1) turned around and started hitting him . R22's face sheet showed he was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. with one intervention added since its initiation. The care plan showed an intervention added on October 20, 2019 which showed, Be firm and remind (R22) that those types of comments are inappropriate and that he needs to stop. Redirect him to another area away from others. The care plan did not address sexually inappropriate behaviors directed toward other residents. On March 5, 2019 at 10:02 AM, V7 (Social Services Director) and V8 (Psychiatric Rehabilitation Services Coordinator) were interviewed together. V7 said she was aware of the incident that occurred between R1 and R2. V7 said R1 reacts violently to sexually inappropriate touching and responds quickly and defensively. V7 said this reaction is because R1's brother had touched her |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>inappropriately when she was a young child. V8 said during a counseling session R1 told her she was raped in the past. V7 said R2 told her he did go into R1's room. V7 said R2 does go into other residents rooms and she has had to talk with him about this. V7 said R2 likes to go into another resident's room and watch her sleep. V7 said in order to protect R1 from R2 she feels that staff would have to be with him at all times, to protect R1 from R3 they are discussing starting him on birth control shots to decrease his sexual drive, and to protect R1 from R22 they have had conversations with him reminding him not to touch or speak inappropriately to other residents. The facility's abuse prevention policy dated February 2020 showed, .this facility affirms the right of our residents to be free from abuse . This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation neglect or abuse of our residents. This will be done by . establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect and abuse of residents . Identifying occurrences and patterns of potential mistreatment, exploitation, neglect, and abuse of residents . sexual abuse is a non-consensual sexual contact of any type with a resident . Resident Assessment. As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis . The facility's resident council meeting minutes were reviewed and showed in December 2019 and January 2020 concerns were discussed with residents going into other resident rooms without permission. |
| F 0602<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Protect each resident from the wrongful use of the resident's belongings or money.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review the facility failed to prevent the theft of resident funds for 15 of 15 resident's reviewed for resident funds and failed to prevent the theft a resident's narcotic medication for 1 resident (R8) in the sample of 28. The findings include: 1. R4's Face Sheet showed an original and current admission date of [DATE] with a [DIAGNOSES REDACTED]. The facility's follow up report to an incident initially reported on 2/19/2020 showed Summary: (R4) requested to review his resident trust statement. Upon review of statement (R4) questioned a $50.00 withdrawal .Upon review of the Resident Trust Cash Box Withdrawal Logs, amended entries were noted. Resident trust account was reviewed and withdrawals from accounts that are uncharacteristic for specific residents were also noted. This investigation is ongoing and complete details will be included in the final report. On 3/3/20 at 9:40 AM, R4 stated I never took that $50 out. I saw it missing on my statement. I would remember that being withdrawn. I got the statement around Christmas time or new years . We only get $30 a month so that was a lot of money for me. I never noticed the money missing because we were not getting (account) statements until just recently .I was pissed off. The facility's investigation showed a sheet of interviews from several residents. R4's statement showed; did not go anywhere or buy anything. The facility's investigation showed a statement from V4 Business Office Manager on 2/20/2020 at 11:00 AM, (R4) was in my office with (V15 Licensed Practical Nurse) and I going over his quarterly trust statement. He was wanting to know his balance. We were showing him the deposits and withdrawals. There was a $50.00 withdrawal back in Aug (August) 2019 he said he did not do. I went in to the file and pulled out the cash registry. (R4's) name and signature were on the registry for $50.00. (R4) said, 'That is not my signature.' (R4) said he never left the facility to go shopping. He said he went out one time to eat at a buffet for around $10.00. He has never sent activities to the store to buy him snacks or pop. The facility's Resident Trust Cash Box Withdrawal Log showed a withdrawal for R4 of $50.00 on 8/21/19 and a $12.00 on 8/29/19. The signatures for these two withdrawals are different in form and in style. The 8/29/19 signature includes a middle initial where the 8/21/19 entry does not. The facility's investigation showed an undated statement from V5 Activity Director in which V5 laid out R4's outings (activities outside the facility). V5's statement showed R4 attended only two outings that required money, both of which were buffet restaurants. One of these was in July 2019 and one was in August 2019; each visit was $12.00. R4's Trust Fund Transaction History Report (TFTHR) showed a $50 withdrawal on 8/23/19 and second withdrawal on 8/29/19 for $12.00. On 3/4/20 at 8:45 AM V1, Interim Administrator stated the date on the TFTHR is whatever date the business office manager entered into the computer and may not reflect the actual date the resident withdrew the money from the cash box. The facility's investigation showed four staff members conducted a room search on 2/20/2020 and There was no money or contraband located . On 3/6/2020 at 11:09 AM, V4 Business Office Manager stated, Only the Business Office Manager has access to the cash box and (V6, previous Business Office Manager) should have been the only one with a key for the box . V4 said the only other person who would have access to her office is the maintenance director and said I 100 percent trust him. On 3/6/2020 at 11:15 AM, when asked if any other employees had been considered for the missing resident funds, V3 Regional Director of Operations stated, It was her (V6's) handwriting in regards to the numerous suspicious entries. V3 said there would be no reason for the maintenance manager to be in the business office managers room and he was not seen in the office. V3 said, if he was seen in the office he would have been questioned about his reason for being in the Business Managers office. On 3/3/2020 at 9:20 AM, V1 Interim Administrator stated, V6 was the employee who stole the money and she was employed from 4/3/18 through 10/10/19. On 3/4/2020 at 8:45 AM, V1 stated V6 was the business office manager starting from the time she was hired. On 3/4/2020 at 1:15 PM, V14 Payroll stated, V6 had four wage garnishments against her totaling approximately $4600. The facility's Abuse Prevention Program policy showed, Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. A shopping receipt was requested relating to the $50 and none was provided. 2. R7's Face Sheet showed a current and original admission date of [DATE]. R7's Care Plan showed he was cognitively intact with a BIMS score of 15 out of 15. On 3/4/2020 at 11:08 AM, V4 Business Office Manager stated, while reviewing Resident Trust Cash Box Withdrawal Log, (R7's) $200 withdrawal really stood out to me because he never leaves facility for outings; he won't even leave to go to the Doctor. He had never came to me and asked for anything except pop but we take care of those pop runs for them. They did do a search of his room after all this came about and no money was found. On 3/4/2020 at 2:45 PM, R7 stated he only spends money on some shirts and that radio; R7 pointed to a small radio on his night stand at the foot of his bed. R7 said, There is nothing I spent $200 on. R7 stated, I don't like to go on outings. On 3/5/2020 at 8:50 AM, V5 Activity Director stated, R7 never goes on outings. He mentioned at a Care Plan meeting that he needed a new radio and some shirts but that was after August 2019. On 3/4/2020 at 10:25 AM, V5 stated she purchased the least expensive radio she could find and she believed it cost $20.99. On 3/4/2020 at 10:25 AM, V5 stated in regards to shopping trips, All receipts must be turned in to the business manager; that is a must. A shopping receipt was requested relating to the $200 withdrawal and none was provided. 3. R5's Face Sheet shows an original and current admission date of [DATE] with [DIAGNOSES REDACTED]. On 3/3/2020, 3/4/2020, and 3/5/2020 R5 was observed during normal business hours walking the hallways and making loud mumbling noises. R5 did not verbally communicate with staff or residents despite staff attempting to get her attention. The facility's Resident Trust Cash Box Withdrawal Log showed an entry for R5 of $70.00 on 9/9/19. This $70.00 entry showed the use of whiteout and when the log was held up to the light, it showed the original entry to be $50. This money was signed for by V4; the current business office manager. A second Log entry on 9/24/19 for R5 showed a $20.00 withdrawal that was changed to $40.00. On 3/4/20 at 11:08 AM, V4 stated, the correct way to make a change to the Resident Trust Cash Box Withdrawal Log would be to put a single line through the error and make a new entry below it. V4 said this is because a person would not know if the alteration was done after the person signed for the money. V4 stated she had a good working relationship with R5 and she was the staff member responsible for taking R5 shopping and to appointments. V4 stated when she would take R5 shopping she would hold up a shirt and R5 would nod her head yes or no. V4 said, regarding R5's $70.00 entry on 9/9/19, Twice I took her to the dentist in Chicago one was September (2019) and one was October (2019). This is my signature (on the log, next to the & $70.00) and the only thing I can think of is we went to (store) . if I saw that whiteout, I would have told (V6 Previous Business Office Manager) to line it out and do a new entry. I would have turned in a receipt for this visit. (Receipt was requested and not provided). $70 seems like a high amount of money to take for her .an average number for her would be $50.00 .It was $50 that was whited over and changed to $70 on 9/9/19. V4 said, in regards to the 9/24/19 entry for $40.00, I took her to the dentist, I only took $20, and that was because we also went to (fast food restaurant). She did not have a copay for the dentist so the $20 was just for food. The (fast food restraint) was under $10 and the change went back to (V6) to be deposited back into R5's account. R5's Trust Fund Transaction History Report showed withdrawals on [DATE] and 9/26/19 for $70.00 and $40.00 respectively. There were no subsequent deposits of any change that was remaining from shopping visits for August 2019 or September 2019. The Report showed a total of $240 in |

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| F 0602<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>cash withdrawals From August through September 2019. 4. R6's Face Sheet shows and original and current admission date of [DATE]. R6's 1/20/2020 Minimum Data Set showed him to be cognitively intact with a Brief Interview for Mental Status of 15 out of 15. R6's Resident Trust Cash Withdrawal Log showed a $75.00 entry on 8/7/19 where the 7 appears to have been originally written as 1. Then entry showed shopping receipt total $9.05. (Nearly $66 dollar difference) Another entry for R6 on 8/14/19, showed an entry that was changed to $75.00. The 8/14/19 entry showed, shopping receipt total $8.22. R6's Trust Fund Transaction History Report showed two $75.00 withdrawals; one on 8/8/19 and another on 8/15/19. The report showed no change from shopping visits was deposited back into R6's account for August 2019 or September 2019. R6's Log showed total cash withdrawals and shopping withdraws for August and September 2019 to be $384.12 (For a resident who purchases potato chips, soft drinks, and occasionally clothing.) On 3/4/2020 at 2:08 PM, R6 had a small flat screen television (approximately 12 inch). No other items of monetary value on display. On 3/4/2020 at 2:08 PM, R6 stated he does not go to the store, he has staff members go for him. R6 said, I've never told a staff member that I needed $75.00 .I have them get me potato chips, soft drinks, and clothing .I bought this TV about three years ago. I have a computer upstairs but I bought that many years ago. I think it's policy not to keep folding money, so I don't keep it. On 3/4/2020 at 10:25 AM, V5 Activity Director stated R6 likes his (brand name) potato chips and basketball shorts. Shorts I've done (purchased for R6) twice in the last six months. I probably take out about $10 to $15 for a trip. Shorts are around $7 to $11. $75 would be unusual for him (R6). (R6) wants his change (from shopping trips) back in his account because it's safer there. The facility's Final Report to the Local State Agency on 3/6/2020 showed suspicious entries for R4, R5, R6, R9, R10, R11, R12, R13, R14, R15, R16, R18, R19, R20. The facility found the total amount of money to $1181.00; however, R7 was not included in this figure (an additional $200) as well as change from shopping trips that was returned to the facility and not deposited into resident accounts. Of the 14 resident's listed as having susupicious entries, the resident with the highest amount was R12 at $358 from August 2019 through October 2019. The final report showed the issue as being R12 signed out, doesn't ask for money. In the months prior to the suspicious activity (June and July 2019) the Resident Trust Cash Box Log showed R12 made no cash withdrawals. 5. The Minimum Data Set of 1/20/20 shows R8 is cognitively intact, frequently has pain, and is on scheduled pain medications. R8's Physician order [REDACTED]. The order shows it was discontinued on 2/21/20 and changed to [MEDICATION NAME]-acet 10-325mg 1 tab every 6 hours (scheduled). This POS shows R8 has [DIAGNOSES REDACTED]. The [DATE] incident report shows an allegation of missing Narcotics was reported. This report shows Investigation: V10 (RN) and V15 (LPN) approached V2 with an allegation of missing [MEDICATION NAME] for R8. V12 (MDS, Acting DON) was asked to provide her (interim DON) with the pink sheets (Controlled Substance Proof of Use Sheets) for all narcotics that had been signed out. V12 provided V2 with 2 separate binders containing pink sheets and stated I know I have more in a file in my office. V12 then returned with a stack of blank pink sheets. V2 then specifically asked for the pink sheets for 2/20 and V12 responded let me check my car, I have a l lot of stuff out there. V12 then came back in and told her they must be at her house . At 11:30 AM, V12 left the facility and returned at 12:45PM with a file folder with narcotic sheets .there was only one pink sheet for 2/3/20 for R8 and all other February pink sheets for R8 could not be located except the one in use (2/18/20). V2 called the pharmacy and the pharmacy confirmed [MEDICATION NAME] 10-325mg was delivered to the facility: 15tabs on 2/3/20, and 30 tabs on [DATE], 2/12/20, and 2/18/20 . The [DATE] card of 30 was to be completed on 2/15/20 and 29 pills were accounted for with 1 allegedly unaccounted for through the investigation. The 2/12/20 card (30 tablets) and pink controlled substance sheet was unaccounted for and cannot be compared therefore investigation of the 30 alleged tabs cannot be definitively accounted for or definitively unaccounted for. This sheet was located on 2/21/20 in the garbage of the DONs work office, during the investigation but was in a disheveled state. Conclusion: The facility is unable to determine the location of the allegedly missing card, the facility is continuing to work with the County Sheriff department .staff have been in-serviced on abuse and neglect. On 3/4/20 at 9:31 AM, V2 said on 2/20/20, two nurses (V10-RN and V15-LPN) came to me and said that something wasn't right because they think one of the pink (controlled substance proof of use) sheets was missing. They said a new card had been opened for R8 and it should not have been. The card in the drawer for R8 was the card that was delivered on 2/18/20. I asked V12 to bring all the pink sheets to me and she was very vague. She brought me two huge binders with most of the pink sheets from 2018, a bunch of blank pink sheets, and came back and told me they might be in her car. It would be unusual for her to have them in her car. She left about 11:30AM, went home to get them, and returned with a folder with nothing I needed. She did not have any from February, and she only had a handful from 2019. A corporate nurse and V1 went to her office to suspend her and found a pink sheet for R8's [MEDICATION NAME] with two meds signed out on 2/12/20, a pink sheet for R8's klonopin, and a medication card that she had ripped up for the [MEDICATION NAME] delivered on 2/12//20. The ripped-up card is the card the nurses still should have been using. There should have been 11 pills according to my math from the card that was delivered on 2/12/20. The 2/12/20 card was found (empty of all pills) in V12's trash can in her office. On 3/5/20 at 8:54AM, V2 said they substantiated 2 cards of missing [MEDICATION NAME] from R8, they are unsure exactly how many pills because they found 2 semi destroyed pink sheets and couldn't tell how many medications had been signed out. R8's Controlled Substance Proof of Use sheet dated 1/16/20 shows ([MEDICATION NAME] 10/325mg) 1 tab by mouth every 6 hours, quantity 30. The last dose given was signed off on 1/26/20 at 12PM by V10 (RN) with a quantity of 1 tablet remaining. No other signatures were on the sheet accounting for the last tablet of [MEDICATION NAME] 10/325mg as being signed out or given to R8. The next Proof of Use sheet dated 1/24/20 for R8 shows another dose of 1 tablet was signed off on 1/26/20 at 12PM equaling 2 tablets given to R8 at the same date and time by V10. On 3/5/20 at 10:45am, V10 looked at the Proof of Use sheet and said after she gave the 12PM dose on 1/26/20 there would have still been 1 tablet left in that card. V10 said she would not have signed the same dose out on a new sheet for a new card of pills because one would have been left over. V10 looked at the signature on the 1/24/20 card and said it looked similar to hers but was not hers, I don't write at all like this pointing to the 6 in 1/26 and the 12P. There was no accounting for the two pills during the facility investigation. V10 said she reported to V2 that R8 had a card of [MEDICATION NAME] missing. I knew because I looked at R8's [MEDICATION NAME] the day before to see if I needed to order new ones. V10 said R8 had 2 cards of [MEDICATION NAME] and the next day I knew the partial card was missing. I'm not sure but I think there could have been six tabs left in the partial card. V10 said she had concerns about narcotic medications missing because we have had cards of [MEDICATION NAME] missing before. On the morning I noticed the card missing, I told V12 (DON) and she told me I probably emptied it. When the card is empty, we attach the pink sheet to the empty card. At the beginning of the shift, V12 ran into the med room and grabbed all the pink sheets and cards that were emptied. That was the first time she has ever done that. She came back in a few minutes later and I told her a card was missing and we need the empty cards and completed pink sheets back. She (V12) said she had already cut them up, and there was a meeting in her office so she couldn't get the pink sheets. I never got the cards or sheets she took. On 3/6/20 at 11:35 AM, V15 (LPN) said two cards of [MEDICATION NAME] had been taken since about 3 weeks ago. V15 said she worked February 14 to February 15, 2020 on the night shift. V15 said when she left the morning of 2/15/20, she counted R8's [MEDICATION NAME] with V12. We signed the sheet that said R8 had a partial card, and a full card of [MEDICATION NAME]. When I came in that night, I noticed she had taken the 12-noon dose out of a new card. She should have taken out of the partial card. V12 came in again on Sunday morning to work for a nurse who did not show up. When I came in [DATE], or 19th, another whole card was started. A whole other card was missing. I reported it to (another facility's DON) because we did not have a DON or administrator at the time. We had a resident on liquid [MEDICATION NAME] and V12 would always come in the medication refrigerator and check it. The bottle of [MEDICATION NAME] would start out cherry pink and by the end the bottle would be clear as water. We all told the old DON (V16) that [MEDICATION NAME] and [MEDICATION NAME] were missing. I feel like she was covering up for V12. On 3/5/20 at 3:35PM, V13 (RN) said she was previously fired because she called in a complaint in July, 2019 for missing [MEDICATION NAME] (for R8). We also had missing [MEDICATION NAME], which was bright blue in color. It was obviously diluted, it started as blue and was nearly clear by the end of the bottle. I told V16 that everyone thought it was V12 who was taking the medication and she brought V12 in to do the investigation. V12 would come to me and tell me R8 needed a [MEDICATION NAME], or a [MEDICATION NAME] and Tylenol, and that she would take it to him. I wouldn't let her. When I asked, R8 said he did not ask V12 for meds. The Pharmacy Proof of Delivery report dated 3/5/20 shows 30 tablets of [MEDICATION NAME]-acet 10/325mg on 1/24/20, [DATE], 2/12/20, and 2/18/20 were delivered for R8. This report shows 15 tabs were delivered on 2/3/20. The facility did not provide the Controlled Proof of Use sheet for the 2/3/20, [DATE], or 2/12/20 packages of the [MEDICATION NAME]-acet 10/325mg. On 3/3/20, V2 provided 2 clear sleeves with ripped and wrinkled pink sheets, and one with a torn-up card inside belonging to R8, that were found in V12's garbage can in her office. The pink Controlled Substance Proof of Use Sheet was crumpled, and appeared like it had been wet and then dried. The bottom section of the sheet where the signatures go, appeared to be cut off in a straight line. The signature part only had two signatures on it, both V12's on 2/12/20 at 12AM, |

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|---|---|---|---|
| | 14E579 | A. BUILDING _____ B. WING _____ | 03/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ROCK RIVER GARDENS | 3601 SIXTEENTH AVENUE STERLING, IL 61081 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0602<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>and 6AM. The sheet had R8s name on it and could be identified as [MEDICATION NAME] -acet 10/325mg, with a date received on 12/20/20. The second sheet found in V12's garbage was for R8, [MEDICATION NAME] 0.5mg, 1 tab at noon, quantity 30. The sheet shows the meds were delivered on 8/16/19. On 3/5/20 at 8:54am, V2 verified the sheet was from September, 2019. V2 said she thought she had this sheet for the nurse signatures. The third clear sleeve had a ripped-up empty card of R8's [MEDICATION NAME] -acet 10-325mg , delivered 2/12/20, quantity 30. It had been ripped and cut into several pieces. On 3/6/20 at 11:45AM, V2 and V3 said V12 was terminated for the two missing cards of [MEDICATION NAME]. One card was found cut up in her garbage, and two Controlled Substance Proof of Use sheets were found crumpled up with water poured on them inside a Walmart bag in her garbage in her office. The facility policy Controlled Substance dated 11/6/18 shows: It is the policy of the facility that all drugs listed as schedule II drugs are subject to specified handling, storage, disposal, and record keeping. 3. If the Controlled Substance count is correct (on delivery), a control sheet for each prescription will be initiated. The control sheet will contain: Resident's name, Ordering physician name, Issuing Pharmacy, Name and strength of drug, Quantity received, date and time received. 4. All Schedule II drugs must be administered and recorded on a disposition sheet as follows: date and time of administering, Signature of nurse administering drug, Quantity of hand/balance left. 8. Discrepancies must be reported immediately to the Director of Nursing who shall investigate as described in the Missing Controlled Substance Policy. When loss, suspected theft or an error in the administration of regulated drug occurs, a report will be filed with the Pharmacist and the Administrator. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure the supervision of a resident with physically aggressive behaviors and failed to follow CHAR (Criminal History Analysis Recommendations) provided for 1 of 3 residents (R1) reviewed for supervision in the sample of 27. The findings include: 1. The facility's investigation into an incident that occurred between R1 and R22 on October 1, 2019 showed while in the dining room a staff member saw R1 punching R22 in the face. The investigation showed R17 had touched R1 on the back as he was trying to maneuver around her which caused R1 to become upset and act out violently. The facility interview with R1 for the investigation showed R1 was upset that a male resident touched her in the back so I punched him in the face. I don't like when people touch me it takes me back to the days I got 'touched'. R1's medical record showed R1 was a [AGE] year old female. R1's medical record showed R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's acute behavioral healthcare hospital discharge paperwork signed July 1, 2019 showed R1 had a history of [REDACTED]. R1's complete current care plan was reviewed. R1's care plan with initiation date of December 2, 2019 showed, (R1) is a a high risk for verbal and physical aggression. (R1) tends to become physical or verbal with others out of nowhere. (R1) has worked on her anger management and has learned new coping skills. (R1) is at risk for verbal and physical altercations evident by her history of behavior . Encourage (R1) to use her coping skills such as walking, listening to music, watching movies, and attending activities. If resident expressing anger with self or others: attempt to determine source of anger and encourage appropriate outlets for expression of same. If unable to redirect from anger and situation remove from situation and provide 1:1 counseling. R1's care plan with initiation date of January 11, 2018 showed, Resident has a conviction history-physical assault related. Needs additional monitoring to ensure respect of other resident rights. CHAR (Criminal History Analysis Report) results resident is a high risk - the resident requires a single room in close proximity to the nursing station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavioral changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated . During episodes of inappropriate behavior, attempt to determine source of agitation by asking open-ended questions and seek to resolve . (There have been no updates made to this care plan since it was initiated on January 11, 2018.) R1's care plan with initiation date of June 23, 2019 showed, (R1) may seek reprisal against another individual if she becomes overwhelmed in situations . If resident expressing anger with self or others: attempt to determine source of anger and encourage appropriate outlets for expression of same . attempt to determine source of anger and remove from situation . R1's care plan did not include her history of sexual abuse and did not include any information regarding her violent reaction to unwanted touching, perceived sexual advances or sexually inappropriate comments made by male peers. On March 3, 2020 at 8:50 AM, R1 was ambulating independently through the halls. R1 was not making eye contact with the other residents in the area and walked from one end of the facility to the other at a rapid pace repeatedly. This surveyor approached R1 and requested to speak with her. R1 walked down to her room which was located one room from the end of the hallway and was not visible from the nursing station. R1 reported a history of sexual assault to this surveyor and said it makes her feel very uncomfortable when she is touched by other residents. R1's acute care hospital paperwork dated October 1, 2019 showed, The patient is a [AGE] year old female who presents to the emergency department from (the facility). She reports she became angry after another resident rubbed her back and it made her feel uncomfortable. She apparently became combative afterwards so was sent to the emergency department . R1's social service progress note dated October 1, 2019 showed, It was reported to me that (R1) got upset after a male resident touched her back and she punched him in the face. (R1) then hit a staff member in the face as he tried to step in between them. She was sent out for an evaluation . R17's nursing progress note dated October 1, 2019 showed, Resident involved in physical contact with peer . resident given ice and [MEDICATION NAME] . R17's medical record showed he was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. On March 5, 2019 at 10:02 AM, V7 (Social Services Director) and V8 (Psychiatric Rehabilitation Services Coordinator) were interviewed together. V7 said R1 reacts violently to sexually inappropriate touching and responds quickly and defensively. V7 said this reaction is because R1's brother had touched her inappropriately when she was a young child. V8 said during a counseling session R1 told her she was raped in the past. V7 said there have been 3 or 4 times when R1 has become physical with other residents. V7 said, One time a resident was making sexual comments about a past boyfriend and she kept telling him to please stop talking to her. We told him numerous times he needs to stop talking to her like that. She punched him . On October 1, 2019 she punched R1 in the face for making sexual comments. V7 said when R17 touched R1's back (9/23/19 incident) she just snapped. V7 said based on R1's history she had a CHAR (Criminal History Analysis Report) done on admission that showed he is a high risk and has to be in a bedroom on her own with no shared bathroom and in close proximity to the nursing station. V7 said R1 resides in a room at the end of the hallway and is not visible from the nursing station. V7 said there are no rooms really in close proximity to the nursing station that can be seen. 2. The facility's investigation in to the incident that occurred between R1 and R22 on September 23, 2019 showed a staff member had heard arguing in the hallway. When the staff member responded to the area she overheard R22 making sexually inappropriate comments to R1. R1 began arguing back and in the moment was unable to control herself and made physical contact with R22's chest. During the facility's investigation R1 was interviewed and said she tried to hit R22 in the face. R1 said R22 pushed her and she hit him in the chest. R22 was unable to be calmed down and this incident resulted in R22 being sent to an acute behavioral hospital for evaluation. R22's nursing progress note dated September 23, 2019 showed, Resident was heard sexually harassing another resident. He pushed the other resident too far with his comments and she swung and made contact twice. It was once on his chin/chest and his chest the second time . R22's social services progress note dated September 23, 2019 showed, (R22) was upsetting a female resident (R1) by saying things to her about sexual contact . This is when the female turned around and punched him in the face . R1's social services progress note dated September 23, 2019 showed, (R1) reported that a male resident (R22) was making inappropriate comments towards her . she told him to stop and leave her alone but the male resident continued and (R1) turned around and started hitting him . R22's face sheet showed he was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. |
| F 0835<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Administer the facility in a manner that enables it to use its resources effectively and efficiently.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility failed to be administered in a manner to ensure policies and procedures were implemented facility wide to prevent the theft of resident funds and resident medications. This applies to all 49 resident residing in the facility. The findings include: The facility census provided on 3/3/2020 showed 49 residents in the facility. 1. The facility's Final |

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| F 0835<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 4)<br>Report to the Local State Agency on 3/6/2020 regarding misappropriation of resident funds showed suspicious entries for R4, R5, R6, R9, R10, R11, R12, R13, R14, R15, R16, R18, R19, R20. The facility found the total amount of money to $1181.00; however, R7 was not included in this figure (an additional $200) as well as change from shopping trips that was returned to the facility and not deposited into resident accounts. The facility's final report regarding Misappropriation of Resident funds showed the missapropriation spanned nearly 4 month time; from the end of June 2019 to the begining of October 2019. On 3/3/2020 at 9:40 AM, R4 stated I never noticed that ($50 transaction) because we were never getting statements until just recently. The facility's undated Resident Funds Policy and Procedure showed, At least quarterly, the facility will provide the resident or his/her representative a written, itemized statement of all transactions to his/her account which occurred in the last quarter .The facility will institute security measures to ensure that resident funds managed by the facility are safeguarded from theft or mismanagement ans shall include; signed vouchers for all resident transactions, computerized tracking of account activity, monthly oversight by the facility Administrator, and signed quarterly statements .require receipts for all purchases made from residents personal monies .Administrator will have ultimate oversight over all aspects of the handling of the resident trust and resident funds . On 3/4/2020 at 11:08 AM, V4 Business Office Manager stated errors in the Resident Trust Cash Withdrawal Log should be lined out and the correct entry placed below it. V4 stated whiteout and writeovers are not allowed because a person would not know if the correction was done after the individual signed for the money. Review of August 2019 and September 2019 Resident Trust Cash Box Withdrawal Log showed 30 whiteout or overwritten entries. The facility's investigation into the missing resident funds included a statement from R21 that residents had not received quarterly statements in two years. On 3/3/2020 at 9:20 AM, V1 Interim Administrator stated she was not the facility's administrator and to her knowledge there was no administrator on record at that time. V1 stated, her first day as interim administrator was the day R4 reported the suspicious transaction, 2/19/2020. On 3/10/2020 at 2:50 PM, V1 stated the resident trust funds should have been reviewed by the administrator monthly and as a licensed Administrator she would have questioned the suspicious entries. Documentation that quarterly statements were given to R4, R5, R6, and R7 for the third quarter of 2019 was requested and not provided. 2. On 3/5/2020 at 10:45 AM, V10 Registered Nurse stated she had concerns about narcotic medications missing because we have had cards of [MEDICATION NAME] missing before. On 3/6/2020 at 11:35 AM, V15 Licensed Practical Nurse (LPN) stated, Two cards of [MEDICATION NAME] had been taken since about 3 weeks ago .When I came in February 18 or 19th, another whole card was started (which meant) a whole other card was missing. I reported it to (another facility's Director of Nursing, DON) because we did not have a DON or Administrator at the time .We all told the old DON (V16) that [MEDICATION NAME] and [MEDICATION NAME] were missing. I feel like she was covering up for V12 (RN/Minimum Data Set nurse). On 3/5/2020 at 3:35 PM, V13 RN said she was previously fired because she called in a complaint in July 2019 for missing [MEDICATION NAME] (for R8). V13 said, I told V16 that everyone thought it was V12 who was taking the medication and she brought V12 in to do the investigation. Record Review showed R8 had been surveyed twice prior regarding incidents that occurred on 10/18/18 and 7/5/19. These investigations substantiated misappropriation of R8's narcotic pain medication. In both these cases, an entire card of [MEDICATION NAME] (narcotic pain medication) was taken. (This current survey will now be R8's third separate incident of misappropriation of narcotic pain medication.) The facility's 2/2020 Abuse Prention Program policy showed resident's have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation .employees of this facility who have been accused of mistreatment, exploitation, neglec, abuse or misappropriation of resident proper will be immediatley removed from resident contact . On 3/10/2020 at 2:50 PM, V1 stated the facility administrator is responsible for administering the abuse program. The facility timeline provided on 3/4/2020 showed a nearly 3 week gap without adminstrator, from 1/29/2020 to [DATE]. The timeline also showed that V12 (suspected of taking narcotic pain medication) was promoted from MDS nurse to interim DON from 11/27/2019 to 2/20/2020. |