STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145658	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE PLUM GROVE	**24 SOUTH PLUM GROVE ROAD PALATINE, IL 60067**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor, supervise, and update a resident care plan with interventions for R2, to protect other residents from R2's negative sexual behavior. As a result,one resident, R1 was inappropriately touched on the breast by R2. Findings include: On 9/15/20 at 10:03am V3 (Certified Nurse Assistant/CNA) stated regularly works in Dementia unit/ 2nd floor. He stated that he is the assigned CNA for R1. He stated that R1 is very confused, ambulatory, keeps on walking within the unit. He is alert to self and will only respond to greetings like Hi and Hello but cannot understand conversation and cannot verbalized needs. He relayed that on 9/1/20 in the morning he observed R2 inappropriately touching the breast of R1 in the dining room area. R2 was sitting in the corner and R1 wandered/walked towards her and he touched her breast. He separated both residents immediately and reported to V7 LPN. He stated that R1 did not response or react when R2 touched her. They monitored both resident but did not document it. On 9/15/20 at 10:20am V6 CNA stated that on 8/28/20 before 6am, when he was making rounds with V14 (CNA), they observed R1 in R2's room. R1 & R2 were on the bed. R1 was sitting on R2 while R2 was touching R1's breast. R1 was fully clothed while R2 wears night gown. They removed R1 from R2's room and reported to V15 Licensed Practical Nurse. Both residents were monitored but he did not document it. 9/15/20 at 10:31am V7 LPN stated that on 8/27/20 around 2pm-2:30pm after R2's wife outdoor visitation, R2 displayed sexually inappropriate behavior and agitation. He propels himself on wheelchair, goes to female residents and employees. He stands up and reaching/grabbing, approaching female residents and employees. She recalled one female CNA told her that his trying to touch her breast. She called V2, director of nurses (DON0 who came to the unit. She took the resident back and tried to calm him down. R2 also tried to touch V2's breast. V2 assigned a 1:1 CNA for R2 until he calms down. She called R2's Nurse Practitioner. She stated she was off the next day and returned to work on 9/1/20. It was endorsed that petition for involuntary admission was prepared and just waiting for behold and nasal swab for COVID test. She stated that she heard from report that on 8/28/20 before 6am, R1 was found in R2's room, she was sitting in his lap while R2 was inappropriately touching her breast. Another episode of inappropriate sexual behavior was exhibited by R2 on 9/1/20 in the morning when he touched R1's breast when she approached him at his table. On 9/15/20 at 1:03pm V12 Social Service/Activity Director stated she is not involved in the investigation of abuse resident to resident allegation for R1 and R2 but she initiated the petition of involuntary admission of R2 prior to 9/1/2020. It was not used because he was sent via 911. She heard that had R1 wandered into R2's room and R2 sexually inappropriately touched her. R1 and R2 are not interviewable. R2 was sent out to the hospital for psych evaluationl because of another episode of touching R1's breast on 9/1/20. She stated that abuse/neglect assessment was done annual or if there are significant changes in resident's mood, physical or behavior. She stated that she did not re-assess R1 and R2's abuse/neglect assessment after the incident because there were no changes in resident's condition. R1 and R2 abuse/neglect assessment was done upon admission, both scored moderately risk, but no abuse/neglect prevention care plan was developed. V1 Administrator made aware of concern identified. On 9/16/20 at 9:34am, V1 (Administrator) admitted that he was aware of the incident of 8/28/20, R1 was found in R2's lap in his room and R2 was touching her breast. He did not report it because he did not think there was abuse going on. Both are confused and showing affection and cannot identify who is the abuser because both are unable to be interviewed. He stated that he did not notify the law enforcement on 9/1/20 because R2 was sent out to the hospital for evaluation. On 9/17/20 at 10:04am, V2 (DON) stated that on 8/27/20 around 2pm, V7 reported that after R2's outdoor visit, R2 displayed sexually inappropriate behavior as he wheels himself to the ambulatory female residents, to different tables, trying to engage with them. He did not respond to redirection and becomes aggressive to staff. V7 came to the unit to calm him down, but he grabbed her shirt and trying to pull it down and attempted to touch her breast. He assigned 1:1 CNA for him.and observation every 15 mins. Requested for 1:1 monitoring documentation but unable to provide. Initial petition for involuntary admission was done but unable to get bed hold without nasal swab for COVID test as required by the behavioral hospital. R2's NP was notified and changed his [MEDICAL CONDITION] medications. On 8/28/20 in the morning, V15 LPN reported to her that R1 was found in R2's room, sitting on his lap and R2 was touching her breast. R1 was removed from R2's bed. Both residents do not have history of sexually inappropriate behavior. Both are confused and not aware of what's happening. V2 admitted that she did not report it because she did not see it as abuse because both residents are confused and not aware of what's happening. On 9/1/20, R2 behavior escalated . R2 grabbed and touched R1's breast when she wandered/walked towards him in the dining room. R2 was sent out to the hospital for psychiatric evaluation on 9/1/20. On 9/17/20 at 11:03am, V6 CNA and V14, CNA stated that they were both working on 8/28/20, around 5:45am when they were making rounds, they found R1 in R2's room sitting in his lap while R2 was touching her breast. R1 is fully dressed while R2 is wearing night gown. V14 stated that she dressed R1 around 3am. V6 stated that R1is usually up early in am, she sleeps only 3-4 hrs and wanders within the unit. They reported to V15, LPN and removed R1 from R2's room. On 9/17/20 at 11:28am ,V8 (MDS Coordinator) stated that she works as MDS Coordinator/Care plan coordinator/Restorative nurse. She stated that she helps to update care plan for all incident reports such as abuse, fall , skin tear. Abuse/neglect screening is done by V12, Social service Coordinator upon admission and if there are any changes in resident conditions or abuse allegations. V12 should developed abuse/neglect prevention care plan for any residents who are moderate to high risk for abuse/neglect. R2 identified care plan: potential for physical aggressive or inappropriately touching other resident or staff initiated on 9/1/20 but was not updated for inappropriate sexual behavior when observed 8/27, 8/28 and 9/1/20. Care plan was updated after surveyor addressed the concerns. Intervention of Psychiatric/psychogeriatric consult as indicated was not done . R1 identified care plan for wanderer initiated on 8/21/20, no individualized interventions developed to prevent/protect her from wandering to R1's room from being touched inappropriately. Care plan in place was not revised/updated. V8 stated that she did not update the care plan because she was on vacation on 8/27/20 and returned to work on 9/1/20. She stated that in her absence V2 ,DON or the floor nurse will update the care plan as needed. She stated that when she returned to work on 9/1/20 she was asked to do the nasal swab COVID test for before they could send R2's petition for involuntary admission to the hospital. On 9/17/20 at 10:30am V7, LPN stated she doesn't update the care plan. She doesn't know how and does not have access to it. On 9/17/20 at 11:41am, V2, DON stated that in absence of V8 Care plan Coordinator, V1 Administrator or V12 Social Service will update the care plan. She does not update the resident's care plan. V2 was aware that R1 and R2's care plan was not updated after the incident happened on 8/27, 8/28 and 9/1/20. On 9/17/20 at 12:20pm, V1 stated that in absence of V8 Care plan coordinator, V2 should update the care plan of R1 and R2. On 9/17/20 at 4:19pm, V15, LPN stated that on 8/27/20 before 6am while making rounds, 2 CNAs, V6 and V14 called her to R2's room . She observed R1 sitting in R2's lap and R2 is touching/holding her breast. CNAs helped her to remove R1 from R2's room. R1 is dressed while R2 was wearing night gown. She charted it as late entry, she was busy at that day but reported it to V2, DON when she came to the floor

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) before she left She stated that V2 will call the family and physician. She added that she should do the risk management charting (incident report) because of R2's inappropriate sexual behavior to R1. She was told by V2 to chart on progress notes because R2 has history of inappropriate sexual behavior. She stated that V2, DON contacted behavioral hospital for involuntary admission but could not get a bed until resident is tested for COVID. Review of the abuse incident report with V1 Administrator indicated: On 9/1/20 R2 was noted displaying inappropriate sexual behaviors toward R1, attempting to grab her breast when she walked near him. R2 is an 81 y/o with dx of dementia with Lewy bodies, Diabetes Mellitus 2, [MEDICAL CONDITION], Hypertension, and Brief Interview of Mental Status (BIMS) =3. R1 is a 54 y/o with dx of Alzheimer's with early onset, [MEDICAL CONDITION], Dementia, Anxiety and BIMS=0. She is alert x 1. Both residents were immediately separated by staff and placed on monitoring until R2 was sent to hospital. R2 was sent to hospital with a petition for psych evaluation and admission. R2 was treated for [REDACTED]. Facility has arranged temporary alternate placement for R2 with additional services. R1 remains at her baseline for mood and behavior. Both POAs made aware and happy with the plan. POA and ombudsman made aware. Management reviewed the medical record for both residents. Employees and residents that were knowledgeable of the incident were interviewed. R1 was not able to participate in an interview. V7, LPN was interviewed by V2 DON. V7stated that she noted R2 being inappropriate attempting to grab R1's private areas. Staff immediately separated them placed R1 on a 1:1 supervision until he was sent to hospital with petition for psychiatric evaluation. R1 is at her baseline for mood and behavior. V13 RA stated she did see R1 in the past attempt to hold R2's hand. V6, CNA stated that he helped separate R1 and R2. R1 appeared at at baselin after the altercation. V14, LPN stated that she noted R1 in R2's bed. R2 was attempting to grab her private areas. Staff immediately separated and placed them both on monitoring. R1's roommate could not participate in an interview due to her cognitive condition. Conclusion and action taken: The evidence indicated that there wasn't any intent to harm and therefore there was no abuse. R2 was evaluated at the hospital and treated for [REDACTED]. The facility, with the consent of R2's POA ,assisted in finding temporary alternative placement with additional psych services. No allegations of abuse were made, . Both R1 and R2's POA stated they were happy with care provided at the facility. R1 remains at her baseline for mood, behavior and ADLs. R1 and R2's representatives were notified regarding investigation, outcome, and corrective actions taken. The ombudsman was notified of the result. Review of R2's petition for involuntary /judicial admitted d 9/1/20 indicated: R2 is an 81 y/o. A &Ox1 is at risk to self and others and unable to function safely, requiring in patient hospitalization r/t aggressive sexual behavior. He is touching other women's breast, attempting to put his hands up their shirts and touching between their legs. Telling them to spread their legs, pulling at women's clothing etc. Witness by : V2 DON, V6 CNA, V7 LPN and V14 CNA. Review of Facility's Abuse Prevention and Reporting revised date 1/23/19 indicated: Page 4: Resident Assessment: As part of the resident social history evaluation and MDS assessment, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or misappropriation of resident property, or 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 abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis. Page 5: Internal reporting requirements and identification of allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act as administrator in the administrator's absence. Reports should be documented, and a record kept of the documentation. Upon learning of the report, the administrator or designee shall initiate an incident. Page 6: Protection of residents: Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. Internal Investigation: All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation or resident property occurred was alleged or suspected. Any incident or allegations involving abuse, neglect, exploitation, mistreatment ot misappropriation of resident property will result in an investigation. Page 7: Investigation procedures: The appointed investigator will at minimum attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Page 8: External reporting: Initial reporting of allegations: When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representation and IDPH regional office shall be informed by telephone or fax. Public health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and its being investigated. Page 9: Informing local law enforcement. The facility shall also contact local law enforcement authorities in the following situation: 3) Sexual abuse of a resident by a staff member, another resident or visitor. Review of Facility's Comprehensive Care Plan revised date 11/17/17 indicated: Page 2: The care plan should be revised on an ongoing basis to reflect changes in the resident and the care plan that the resident is receiving.