STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35510 Based on interview and record review, the facility failed to supervise residents (R1 and R2) with a known history of inappropriate sexual behavior to prevent resident to resident sexual abuse. This failure resulted in R2 being sexually abused by R1. Staff allowed R1 and R2 to go unsupervised with unrestricted access to each other resulting in sexual behaviors between two residents who are unable to consent, exposing them to abuse. This failure affects two (R1, R2) of residents reviewed for abuse in the sample list of 12 residents. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 10/5/21 at 10:25am, onsite observation, interview and record review verified the facility is in the process of training staff, including re-education on the facility abuse policy and monitoring R1 and R2. The facility remains out of compliance at a severity level two. Findings include: R1's Physician's Notes dated 4/9/21, documents R1's diagnoses including Cerebrovascular Accident (CVA), Dementia and memory loss. This note documents R1 had been hospitalized and was evaluated while in the hospital and felt to be incompetent. R1's Brief Interview for Mental Status dated 7/19/21 documents R1 is severely cognitively impaired. R2's Care Plans dated 1/14/2013, document R2 has a diagnosis of Pick's Dementia and requires supervision and cues to complete activities of daily living and wanders around the facility. These Care Plans also document R2 has a history of inappropriate display of sexual behavior related to R2's diagnosis of Picks Dementia. 9/5/21 11:15 am, R1's Progress Notes document R1 was found next to R2 in a recliner. This note documents V3, Licensed Practical Nurse (LPN) observed R1 attempting to put (R1's) hands on (R2) inappropriately. V3 intervened and separated R1 and R2. V3 notified V16 Regional Director (RD). This note documents will continue to monitor (R1) and keep separate from females. (continued on next page)

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.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's interview dated 9/9/21 with V3, documents resident incident and that V3 overheard another staff (unidentified) saying R1 had sat in recliner with R2. When V3 investigated, (V3) saw R1 trying to place R1's hands inside R2's pants, grabbing R2's waistband and trying to put (R1's) fingers in. 9/5/21 11:49am, fax notification sheet to V7 (Physician) documents Another resident (R1) attempted to sexually inappropriate touch (R2)., there was no further interventions documented. R1's Progress Notes dated 9/5/21 7:40pm document, on 9/5/21 at 5:30pm, V4 (Registered Nurse - RN) responded to a call light that was sounding. V4 and V5 (Certified Nursing Assistant - CNA) walked into the room and observed R2 laying on R2's back on a bed with R2's pants down. This note documents R2's feet were in front of R2's vaginal area. R2 was laying the wrong way, positioned across the bed with R2's head toward the wall. R1 had R1's pants down and turned around when V4 and V5 entered the room. R1 saw V4 and V5 and pulled up R1's pants and started to exit the room. V5 escorted R1 out of the room. V4 assisted R2 to get R2's pants pulled up and walked (R2) out of the room. This note also documents both R1 and R2 have Dementia and wander throughout the facility. R2 is unable to communicate. (R2) didn't look like anything had occurred because there were no sign of body fluids, etc. R1's Hospital emergency room physician notes dated 9/5/21, document R1 is oriented to person only, ambulates to the bathroom and is up in the room without difficulty. This note documents R1 was found standing in a female resident's (unidentified) room with no clothes on. On 9/21/21 at 2:15pm, V4 Registered Nurse (RN) stated V4 was the nurse on duty on 9/5/21 and was one of the staff members to answer the call light and observe the inappropriate sexual behavior. V4 stated V4 felt R1 knew what (R1) was doing because as soon as V4 and V5 answered the call light and found R1 and R2 with their pants down in the room, R1 immediately pulled R1's brief and pants up and began to leave the room. V4 stated R1 was fixated on R2 for a couple of days following the incident. V4 stated V4 found R1 holding R2's hand in the dining room as V4 documented on 9/7/21. This was two days after R1 and R2 were found in the room with no clothing on from the waist down. V4 stated R1 and R2 were behind V4 when V4 turned around and witnessed the hand holding. V4 stated R2 could not have removed/taken R2's pants down by R2's self. V4 stated R2 had the call light in one of R2's hands but could not recall which hand, which was odd because R2 doesn't know how to use the call light. V4 stated when V4 came in to work that day (9/5/21) around 2:00pm, during report with the nurse (V4 could not remember who the nurse was) it was mentioned something had happened and everyone was notified that needed to be. V4 could not remember what V4 was told that had happened. Regarding the 9/5/21 5:30 pm incident, V4 stated R2's feet were propped up on the bed with knees bent upward and R1 was standing right in front of R2. V4 stated V4 spoke with the local police department to report the sexual abuse incident. V4 stated R1 and R2 were at the bed that is closest to the door of the room with R2 laying on R2's back. R2's body was across the bed against the wall with head by wall. R1 and R2 both had their pants and briefs down, exposing themselves to each other. V4 stated V4 assisted R2 to pull R2's brief and pants up. V4 stated V5 escorted R1 out of the room. V4 was unsure of when R1 and R2 were last observed together. V4 did not know where R1 was taken when V5 escorted R1 out of the room. V4 stated staff mentioned when R2 was first admitted to the facility, that R2 had promiscuous behaviors and residents would take advantage of that. V4 stated that on 9/6/21 R1 kept circling R2 and was fixated on R2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/23/21 at 10:10am, V12 (Housekeeper) stated V12 observed R1 dipping (R2's) hand in (R1's) pants. V12 stated R1 kept trying to put R1's hands in/down the front of R2's pants multiple times. V12 stated R1's hand was down (R2's pants) enough to R1's knuckles and was trying to push down further in to R2's pants. V12 stated V12 had not been contacted by V1 (Administrator in Training - AIT) for an interview regarding the incident on 9/5/21. V12 stated R1 was purposefully touching R2 in a sexually inappropriate way and R2 would not be able to consent or know what was happening. On 9/23/21 at 12:05pm, V15 (Cook) stated V15 came out of kitchen on 9/5/21 (unsure of what time) and saw R1 sitting next to R2 with R1's arm around R2 and leaning in to (R2). V15 stated V15 told staff standing there, you know how (R1) is and you better get (R1), that is not right. V15 stated R1 and R2 are not cognitively aware to make those decisions. V15 stated some staff thought it was cute. V15 stated when V3 (LPN) responded, R1 was trying to put R1's hands down R2's pants. V15 stated V15 was not contacted for a witness interview related to R1 and R2's sexual inappropriateness on 9/5/21 at 11:15am. R1's Pharmacy Consultation Report dated 9/10/21, documents R1 has experienced an increase in unusual behavior patterns (resident to resident sexual behaviors and inappropriate remarks). An Immediate Jeopardy situation was identified on 09/27/21 at 3:33pm. The Immediate Jeopardy was identified to have begun on 9/5/21 at 11:15am, when R1 was observed touching R2 in a sexually inappropriate way. R1 and R2 were not kept separated/supervised. On 9/5/21 at 5:30pm, R1 and R2 were found in the room of other residents, both with pants down, exposing their lower bodies, perineal areas to one another. R2 was on the bed laying across the bed with buttocks toward the outer edge of the bed and head to the wall with R1 standing in front of R2. On 09/27/21 at 3:33pm, V16 Regional Director (RD) was notified of the Immediate Jeopardy situation. The surveyor confirmed through observation, interview and record review that the facility took the following actions to remove the immediate jeopardy: 1.) On 9/27/21, V16 Regional Director (RD) in-serviced V1 Administrator in Training (AIT) on the Abuse Prohibition Policy and the importance of completing a thorough investigation on all allegations/incidents. V1 also received education regarding the importance of ensuring 1:1 supervision and 15-minute visual checks are carried out and documented. 2.) On 10/5/21 at 10:25am, V1 provided documentation that additional in-servicing on the facility's Abuse policy was initiated on 10/5/21. The facility will complete random weekly in-services on the facility Abuse policy and the importance of ensuring residents receive 1:1 supervision or 15-minute checks that require are required. There is no documentation of this being completed after 9/25/21 as of 10/4/21. 3.) Social Services (SS) and Activities departments have increased their sessions with R1 and R2, working with R1 and R2 separately. Per V1, V24 (Social Services) stated V24 was unable to complete the number of sessions (3 sessions weekly) as documented in the facility's abatement plan. There is no documentation that V9 (Activities Director) has increased R1 or R2's activity sessions since 9/27/21. The facility is working with V9 as to where those sessions can be documented. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4.) On 10/4/21 at 11:00am, V1 provided updated documentation that the Interdisciplinary Team (IDT) reviewed residents involved in resident-to-resident abuse allegations to ensure resident specific targeted behaviors have appropriate person-centered interventions. 5.) On 9/27/21 the IDT was in-serviced by V16 (Regional Director) to review residents for changes in behaviors to investigate and identify any potential triggers prior to an incident. The in-service included to ensure that resident centered interventions are developed to alleviate/decrease behaviors and to communicate identified triggers and interventions to staff (Completion date of 9/27/21). 6.) Residents identified during IDT review for behavioral changes in #5 will be discussed during morning meeting and a root cause analysis will be completed to determine potential triggers. 7.) New interventions will be communicated to staff using a communication book. As of 10/4/21 at 2:10pm, V4 Registered Nurse (RN) was unaware of the communication book and did not know what staff or V4 was supposed to do with the book or what it was for. V1 (Administrator in Training) stated V1 is updating (direct care staff) when (V1) sees them related to the communication book.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35510 Based on interview and record review, the facility failed to implement their Abuse Prohibition Policy by failing to ensure residents were free from sexual abuse, failed to protect residents from further abuse, failed to report allegations of abuse to the State Survey Agency and failed to complete a thorough investigation for abuse allegations. The facility also failed to notify the resident's representative of the results of the abuse allegation investigation. These failures have the potential to affect six residents (R1, R2, R4, R7, R8, R11) reviewed for abuse allegations in the sample of 12. Findings include: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Abuse Prevention Program policy dated 11/28/2016, documents the facility affirms the right of the residents to be free from abuse. 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 the residents of the facility. The policy documents this will be done by multiple actions including identifying occurrences and patterns of potential mistreatment, exploitation, neglect, abuse of residents and misappropriation of property promptly and aggressively and making the necessary changes to prevent future occurrences. The facility is committed to protecting the residents of the facility from abuse by anyone including but not limited to facility staff and other residents. This policy documents the definition of sexual abuse as non-consensual sexual contact of any type with a resident. This policy documents as a part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs or behaviors that may lead to conflict. Through the care planning process, the facility will identify problems, goals and approaches to reduce the chances of abuse of these residents. Employees are immediately required to report any occurrences of potential/alleged mistreatment, exploitation, neglect and abuse of residents they observe, hear about or suspect to a supervisor and the administrator. Supervisors shall immediately inform the administrator, or the administrators designated representative of all reports of potential/alleged mistreatment and abuse of residents. Upon learning the report, the administrator shall initiate an investigation. This policy documents the facility will take steps to prevent mistreatment and abuse of residents while the investigation is in progress. This includes residents who allegedly mistreat or abuse another resident will be removed from contact with that resident 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 residing in the facility. Employees accused of mistreatment or abuse shall not complete their shift as a direct care provider to residents, be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. The appointed investigator will follow the resident protection investigation procedures which contain specific investigation paths depending on the nature of the allegation. The final investigation report shall contain information including the following: The original allegation noting date, time, location, the specific allegation, by whom, witnesses and circumstances surrounding the incident; Facts determined during the process of the investigation, review of medical records and interviews of witnesses; Conclusion of the investigation based on known facts; If there is a police report, attach the police report; and attach a summary of all interviews conducted with the names, addresses and phone numbers of all witnesses. The Administrator or designee is responsible for forwarding a final written report of the results of the investigation and any corrective action taken by the facility. The Administrator is also responsible for informing the resident or their representative of the results of the investigation and of any corrective action taken. The facility must ensure all alleged violations involving mistreatment or abuse are reported immediately to the administrator of the facility and to other officials in accordance with state law. This policy documents determine one of the specific investigation paths to follow which includes possible sexual abuse and possible verbal, exploitation or mental abuse. The investigation shall include: interviews with any witnesses to the incident, an interview with the resident, a review of medical records of any residents involved in the occurrence. The investigation shall also include: a review of the personnel file if the accused individual is an employee, interview with staff members having contact with the resident and accused individual during the period of the alleged incident, interviews with others in the vicinity of the incident and other residents whom which the accused individual has regular contact, other employees related to any incidents of mistreatment involving the accused individual and a review of all circumstances surrounding the incident. The Resident Protection Investigation Paths within the facility's Abuse Prevention Program policy documents for possible sexual abuse to determine if the allegation involves physical sexual contact involving penetration, verbal harassment or physical contact that did not involve penetration. If allegation of physical sexual contact with penetration is involved do not shower bathe or change clothes of the person attacked. If clothes have been changed, save for inspection. In cooperation with the police, have the resident examined at the hospital. Leave any bed linens in place, do not touch or move anything in the area of the alleged offense pending further direction from involved law enforcement agencies. Proceed with the facility's own investigation. The protection path for Verbal, Exploitation or Mental Abuse documents even if the resident

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R1's Progress Notes dated 9/5/21 at 11:15am document R1 was found next to R2 in a recliner. This note documents V3, Licensed Practical Nurse (LPN) observed R1 attempting to put (R1's) hands on (R2) inappropriately. V3 intervened and separated R1 and R2. V3 notified V16 Regional Director (RD). This note documents will continue to monitor (R1) and keep separate from females. 9/5/21 11:49 am, fax notification sheet to V7 (Physician) documents Another resident (R1) attempted to sexually inappropriate touch (R2)., there was no further interventions documented. On 9/23/21 at 10:10am, V12 (Housekeeper) stated V12 observed R1 dipping (R2's) hand in (R1's) pants. V12 stated R1 kept trying to put R1's hands in/down the front of R2's pants multiple times. V12 stated R1's hand was down (R2's pants) enough to R1's knuckles and was trying to push down further in to R2's pants. V12 stated V12 had not been contacted by V1 (Administrator in Training - AIT) for an interview regarding the incident on 9/5/21. V12 stated R1 was purposefully touching R2 in a sexually inappropriate way and R2 would not be able to consent or know what was happening. On 9/23/21 at 12:05pm, V15, Cook stated V15 witnessed R1 and R2 sitting in the oversized recliner with R1's arm around R2 on 9/5/21 just after lunch. V15 stated V15 knew it wasn't right. V15 stated V15 was not contacted for a witness statement for this allegation of abuse. There is no documentation this sexual abuse allegation on 9/5/21 at 11:15am was reported to the State Survey Agency or was investigated thoroughly. On 9/23/21 at 2:30pm, V16, Regional Director (RD) stated V3, LPN notified V16 of the allegation between R1 and R2. V16 stated V3 had reported nothing happened and that is why it was not reported to the State Survey Agency. V16 stated V16 was unaware V12, Housekeeper and V15, Cook were witnesses to the sexual abuse allegation on 9/5/21 at 11:15am. 2. R1's Progress Notes dated 9/5/21 7:40pm document, on 9/5/21 at 5:30pm, V4 (Registered Nurse - RN) responded to a call light that was sounding. V4 and V5 (Certified Nursing Assistant - CNA) walked into the room and observed R2 laying on R2's back on a bed with R2's pants down. This note documents R2's feet were in front of R2's vaginal area. R2 was laying the wrong way, positioned across the bed with R2's head toward the wall. R1 had R1's pants down and turned around when V4 and V5 entered the room. R1 saw V4 and V5 and pulled up R1's pants and started to exit the room. V5 escorted R1 out of the room. V4 assisted R2 to get R2's pants pulled up and walked (R2) out of the room. This note also documents both R1 and R2 have Dementia and wander throughout the facility. R2 is unable to communicate. (R2) didn't look like anything had occurred because there were no sign of body fluids, etc. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/21/21 at 2:15pm, V4 Registered Nurse (RN) stated V4 was the nurse on duty on 9/5/21 and was one of the staff members to answer the call light and observe the inappropriate sexual behavior. V4 stated V4 felt R1 knew what (R1) was doing because as soon as V4 and V5 answered the call light and found R1 and R2 with their pants down in the room, R1 immediately pulled R1's brief and pants up and began to leave the room. V4 stated R1 was fixated on R2 for a couple of days following the incident. V4 stated V4 found R1 holding R2's hand in the dining room as V4 documented on 9/7/21. This was two days after R1 and R2 were found in the room with no clothing on from the waist down. V4 stated R1 and R2 were behind V4 when V4 turned around and witnessed the hand holding. V4 stated R2 could not have removed/taken R2's pants down by R2's self. V4 stated V4 was unsure if the sexual abuse incident involved penetration because V4 did not complete a pelvic exam. V4 stated when V4 came in to work that day (9/5/21) around 2:00pm, during report with the nurse (V4 could not remember who the nurse was) it was mentioned something had happened and everyone was notified that needed to be. V4 could not remember what V4 was told that had happened. Regarding the 9/5/21 5:30 pm incident, V4 stated R2's feet were propped up on the bed with knees bent upward and R1 was standing right in front of R2. V4 stated V4 spoke with the local police department to report the sexual abuse incident. V4 stated R1 and R2 were at the bed that is closest to the door of the room with R2 laying on R2's back. R2's body was across the bed against the wall with head by wall. R1 and R2 both had their pants and briefs down, exposing themselves to each other. V4 stated V4 assisted R2 to pull R2's brief and pants up. V4 stated V5 escorted R1 out of the room. V4 was unsure of when R1 and R2 were last observed together. V4 did not know where R1 was taken when V5 escorted R1 out of the room. V4 stated staff mentioned when R2 was first admitted to the facility, that R2 had promiscuous behaviors and residents would take advantage of that. V4 stated that on 9/6/21 R1 kept circling R2 and was fixated on R2. V4 stated R2 did not go to the hospital for evaluation related to the sexual abuse incident on 9/5/21 at 5:30pm but R1 was sent to the hospital after V4 finished passing medications to the residents at the facility. There is no documentation R2 was taken to the hospital for examination after R1 and R2 were found exposed from the waist down with R1 standing in front of R2. There is no documentation R1 or R2's representatives were notified of the results of the sexual abuse allegation investigation. There is no documentation the facility saved/protected the clothing or linens from the bed where R2 was laying at the time of the incident. There is no documentation of completion of a thorough exam or pelvic exam for R2. There is also no documentation of a copy of the police report in this investigation. On 9/23/21 at 12:30pm, V1 Administrator in Training (AIT) stated, V16 Regional Director (RD) was on call for V1 due to V1 being off on vacation. V1 stated V1 was not notified of the sexual abuse allegation between R1 and R2 but found out about it when V1 returned to work on 9/6/21 and received documentation for the allegation. V1 stated V1 did not speak with V4, Registered Nurse (RN) in regard to the incident. V1 stated V4 and V5 (CNA) did not think anything happened (sexual penetration) but there was no confirmation of no penetration. V1 stated V16 did not say if V16 spoke to anyone else, staff or residents, regarding the sexual abuse incident earlier that day prior to the 9/5/21 evening sexual abuse incident. V16 did not have any notes or statements. V1 stated V1 thought the earlier sexual abuse incident (9/5/21 11:15 am) had been taken care of and V1 did not investigate that incident any further. V1 stated V1 did not review the cameras in the facility to try and gather information/facts surrounding either sexual abuse incident on 9/5/21 between R1 and R2. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility's investigation for the allegation of verbal abuse, between V17 Licensed Practical Nurse (LPN) towards R7 on 8/14/21, documents V1 (Administrator in Training - AIT) was notified of the allegation on 8/14/21. This investigation documents V17 was removed from care however, there is no documentation of when V17 was suspended or when V17 returned from the suspension for the allegation. This investigation documents V18 (R7's Family) was notified of the allegation of verbal abuse, but there is no documentation that V18 was notified of the results of the investigation. The Fax Worksheet State Survey Agency Notification Form dated 8/14/21 documents R7 reported to V9 (Activity Director/CNA) that R7 felt V17 spoke inappropriately to R7. V17 removed from care and notifications were made. This form documents the allegation as verbal abuse. This investigation documents a witness statement from V17 documenting V17 had a good shift today. Nothing out of the ordinary occurred and no issues all shift. This statement documents V1 asked V17 if V17 had noticed an increase in paranoia with R7 and V17 stated no. There is no documentation of V17 being asked if V17 made a comment about R8 (R7's roommate) knowing more about R7's clock than R7 does. This investigation documents a Final Report, dated 8/18/21, for the verbal abuse allegation between R7 and V17 that was reported on 8/14/21. This Final Report to the State Survey Agency does not document which other residents were interviewed and what those residents stated. This report documents no other staff concerns but does not document which staff were interviewed or what was said. This conclusion documents state, after completing a thorough investigation it appears R7's behavior and delusions has increased since 7/1/21 and that R7 refuses assistance from psychiatric services. There is no documentation in the investigation of R7's increased behavior/delusions. There is no documentation of V17's dates of suspension while investigation was in progress. V17's Punch Detail Report documents, V17 worked after the facility was notified of the allegation of verbal abuse by V17 to R1 on 8/15/21 from 6:20am to 1:29pm while the investigation was still in progress and not finalized. The Final Report for the verbal abuse allegation on 8/14/21 for R7 and V17 dated 8/18/21, documents V9 reported to V1 that R7 stated V17 speaks mean to R7 and that R8 (R7's roommate) knows more about the clock than R7 does. No additional concerns noted by other residents including the resident's roommate (R8). The facility's investigation does not contain a copy of the police report, but the facility documents they notified the police. The summary of witness statements only contains two staff members. There is no documentation the resident's representative, or the resident was notified of the results of the investigation. There is no documentation of any corrective action taken in response to their conclusion. There is no documentation V17's personnel file was reviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/29/21 at 12:00pm, V1 stated R7 told V9 that V17 speaks mean to R7. V1 stated V1 thinks V17 was off at 5pm on 8/14/21. V1 stated the conclusion of the investigation was that R7 had increase in behavior and delusions 2020 and R7 was removed from psychiatric services due to refusing them. V1 stated V1 thinks they were looking through the nurse's notes and Medication Administration Record to see if R7 had been taking R7's medications. V1 doesn't believe R7 was taking medications. V1 stated V1 asked V17 about R7's clock and that V17 stated the clock was discussed 2 weeks prior. This is not documented in the investigation. V1 stated V17 returned on V17's next shift but could not remember when that was. 4. The facility's Final Report, dated 8/10/21, documents R4 and R11 were involved in an abuse allegation (unidentified type by facility) on 8/6/21. The alleged perpetrator is documented as V19 (Housekeeping). V20 (Certified Nursing Assistant) overheard V19 asking R4 and R11 to hurry up and finish so V19 could clear the table. This report documents no other concerns noted. There was no summary of interviews documented for other residents interviewed or a statement from V20 who reported the verbal abuse allegation on 8/6/21 by V19. V20 stated it had happened in the morning of 8/6/21 as well. V20 stated V20 should have reported it then but didn't. V19 stated V19 was just trying to hurry and did not mean to be mean and that V19 has a job to do. V19 stated V19 simply asked them (R4 and R11) to hurry up and finish. The facility's investigation documents a witness statement from V20, stating V20 overheard V19 telling residents V19 had too much to do to have to come back and clean up their dishes. This statement documents V20 made the mistake of not reporting it this morning but again this afternoon at lunch, (V19) was saying it again in particular to R11. V19 asked R11 if R11 was done (with meal) to which R11 replied R11 was not finished. V19 then said, I (V19) don't have time for this, I'm (V19) not clearing dishes again. V20's statement also documents V21, Physical Therapy Assistant (PTA) came to V20 hearing things V19 was saying, so V20 reported it. This report documents the Investigation Conclusion: V19, Housekeeping, has a delayed mental disability and was trying to get V19's tables bussed and simply asked a resident to hurry up so he could get the table cleared. No resident harm, residents have no concerns and employee was addressed accordingly. There is no documentation of what V19's delayed mental disability is or that V19 has one in V19's personnel file or the investigation. There is no documentation V19's personnel file was reviewed. The final report does not document summaries of the additional residents interviewed regarding V19 and/or the incident on 8/6/21. There is no documentation resident representatives were notified of the conclusion/findings of the investigation. V19's Notice of Termination dated 8/9/21 documents, V16 Regional Director (RD) notified V19 of the facility's decision to terminate V19's employment with reasoning including on 8/6/21 V19 was rushing residents to finish so (V19) could get (V19's) tables cleared. This notice documents V16 felt this job was too much for V19 and feel it will continue to be a stressor to V19. On 9/29/21 12:45pm, V1, Administrator in Training stated V1 helped with the investigation for the allegation against V19. V1 stated V19 was terminated in part due to the statements made by V19 toward R4 and R11. V1 stated V20 was terminated for not reporting an allegation of verbal abuse by V19 earlier in the day on 8/6/21. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is no documentation the allegation of verbal abuse on 8/6/21 earlier that day, prior to the one at lunch time, was investigated or reported to the State Survey Agency.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35510 Based on interview and record review, the facility failed to ensure allegations of sexual abuse and verbal abuse were reported to the facility's Abuse Coordinator and the State Survey Agency. This failure affects four residents (R1, R2, R4, R11) reviewed for abuse allegations in the sample of 12. Findings include: 1. R1's Progress Notes dated 9/5/21 at 11:15am document R1 was found next to R2 in a recliner. This note documents V3, Licensed Practical Nurse (LPN) observed R1 attempting to put (R1's) hands on (R2) inappropriately; V3 notified V16, Regional Director (RD). The fax notification sheet dated 9/5/21 at 11:49am documents Another resident (R1) attempted to sexually inappropriate touch (R2). On 9/23/21 at 10:10am, V12, Housekeeper stated V12 observed R1 dipping (R2's) hand in (R1's) pants on 9/5/21 around lunch time. V12 stated R1 kept trying to put R1's hands in/down the front of R2's pants multiple times. V12 stated R1's hand was down (R2's pants) enough to R1's knuckles and was trying to push down further in to R2's pants. There is no documentation this sexual abuse allegation on 9/5/21 at 11:15am was reported to the State Survey Agency. On 9/23/21 at 2:30pm, V16, Regional Director (RD) stated V3, LPN notified V16 of the allegation between R1 and R2. V16 stated V3 had reported nothing happened and that is why it was not reported to the State Survey Agency. V16 stated V16 was unaware V12 was a witness to the sexual abuse allegation on 9/5/21 at 11:15am. 2. The facility's Final Report dated 8/10/21 documents R4 and R11 were the residents involved in the abuse allegation (unidentified type by facility) on 8/6/21. The alleged perpetrator is documented as V19, Housekeeping. V20 (Certified Nursing Assistant) CNA overheard V19 asking R4 and R11 to hurry up and finish their meal so V19 could clear the table. This report documents V20's statement that the verbal abuse had happened in the morning on 8/6/21 as well and V20 stated V20 should have reported it then but didn't. On 9/29/21 at 12:45pm, V1, Administrator in Training (AIT) stated there is no documentation the additional allegation of the verbal abuse allegation from the morning of 8/6/21, prior to the second verbal abuse allegation at lunch time was investigated. V1 stated V19, Housekeeping was terminated in part due to the verbal abuse allegation and V20, CNA was terminated for not reporting an allegation of verbal abuse timely.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 35510 Based on interview and record review, the facility failed to complete and document thorough investigations for allegations of verbal abuse and sexual abuse and failed to prevent further potential abuse while the investigations for abuse allegations were in progress. These failures have the potential to affect five residents (R1, R2, R4, R7, R11) reviewed for abuse allegations in the sample of 12. Findings include: 1. 9/5/21 11:15 am, R1's Progress Notes document R1 was found next to R2 in a recliner. This note documents V3, Licensed Practical Nurse (LPN) observed R1 attempting to put (R1's) hands on (R2) inappropriately. V3 intervened and separated R1 and R2. V3 notified V16 Regional Director (RD). This note documents will continue to monitor (R1) and keep separate from females. The fax notification sheet dated 9/5/21 at 11:49am documents Another resident (R1) attempted to sexually inappropriate touch (R2). On 9/23/21 at 10:10am, V12 (Housekeeper) stated V12 observed R1 dipping (R2's) hand in (R1's) pants. V12 stated R1 kept trying to put R1's hands in/down the front of R2's pants multiple times. V12 stated R1's hand was down (R2's pants) enough to R1's knuckles and was trying to push down further in to R2's pants. V12 stated V12 had not been contacted by V1 (Administrator in Training - AIT) for an interview regarding the incident on 9/5/21. On 9/23/21 at 12:05pm, V15 (Cook) stated V15 witnessed R1 and R2 sitting in the oversized recliner with R1's arm around R2 on 9/5/21 just after lunch. V15 stated V15 knew it wasn't right. V15 stated V15 was not contacted for a witness statement for this allegation of abuse. There is no documentation this sexual abuse allegation on 9/5/21 at 11:15am was investigated. On 9/23/21 at 9:42am, V3, Licensed Practical Nurse (LPN) stated the staff moved R1 and R2 to different chairs in the same area because V3 did not want R1 to come back over and sit back by (R2) again in the oversized recliner. V3 stated V3 called V16, Regional Director and explained what happened and that V3 was not sure what to do about the situation. V3 stated V3 did not send a report to public health related to the sexual abuse allegation nor notify the police because V3 did not see R1 put R1's hand down R1's pants so V16 did not think it was necessary to complete a sexual abuse allegation investigation. V3 stated R1 wandered around the facility that afternoon and kept trying to wander down the hall where female residents are located. V3 stated V3 left the facility around 2:00pm on 9/5/21. V3 could not remember the last time V3 had seen R1 at the end of V3's shift prior to leaving. On 9/23/21 at 2:30pm, V16, Regional Director (RD) stated V3, LPN notified V16 of the allegation between R1 and R2. V16 stated V3 had reported nothing happened and that is why it was not reported to the State Survey Agency. V16 stated V16 was unaware V12, Housekeeper and V15, Cook were witnesses to the sexual abuse allegation on 9/5/21 at 11:15am. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Progress Notes dated 9/5/21 at 7:40pm document on 9/5/21 at 5:30pm (6 hours and 15 minutes after the initial sexual abuse allegation involving R1 and R2), V4 (Registered Nurse-RN) responded to a call light that was sounding. V4 and V5, Certified Nursing Assistant (CNA) walked into the room and observed R2 laying on R2's back on a bed with R2's pants down. R2 was laying the wrong way positioned across the bed with R2's head toward the wall. R1 had R1's pants down and was standing in front of R2. This note also documents both R1 and R2 have Dementia and wander throughout the facility. There is no documentation R2 was thoroughly physically assessed and/or evaluated after the sexual abuse allegation on 9/5/21 at 5:30pm. On 9/21/21 at 2:05pm, V4 (Registered Nurse-RN) stated, R1 was found with R2 in another resident's room with no clothing on from the waist down for R1 and R2. V4 was unsure of where R1 and R2 had been prior to finding them in the room undressed from the waist down. V4 stated V4 looked but did not complete an actual physical thorough pelvic exam on R2 nor was R2 sent out for evaluation in relation to the sexual abuse incident on 9/5/21 at 5:30pm. 2. The facility's investigation for the allegation of verbal abuse between V17 (Licensed Practical Nurse LPN) to resident R7 on 8/14/21 documents V1 (Administrator in Training-AIT) was notified of the allegation on 8/14/21. This investigation documents V17 was removed from care but there is no documentation of when V17 was suspended or when V17 returned from the suspension for the allegation. The Fax Worksheet State Survey Agency Notification Form dated 8/14/21 documents R7 reported to V9 that R7 felt V17, LPN spoke inappropriately to R7. V17 was removed from care and notifications were made. This form documents the allegation as verbal abuse. This investigation documents a Final Report, dated 8/18/21, for the verbal abuse allegation between R7 and V17 that was reported on 8/14/21. This Final Report to the State Survey Agency does not document which other residents were interviewed and what those residents stated. This report documents no other staff concerns but does not document which staff were interviewed or what was said. This conclusion documents state, after completing a thorough investigation it appears R7's behavior and delusions has increased since 7/1/21 and that R7 refuses assistance from psychiatric services. There is no documentation in the investigation of R7's increased behavior/delusions. There is no documentation of V17's dates of suspension while investigation was in progress. V17's Punch Detail Report documents, V17 worked after the facility was notified of the allegation of verbal abuse by V17 to R1 on 8/15/21 from 6:20am to 1:29pm while the investigation was still in progress and not finalized. The facility's investigation does not contain a copy of the police report, but the facility documents they notified the police. The summary of witness statements only contains two staff members. There is no documentation the resident's representative, or the resident was notified of the results of the investigation. There is no documentation of any corrective action taken in response to their conclusion. There is no documentation V17's personnel file was reviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/29/21 at 12:00pm, V1 stated R7 told V9 that V17 speaks mean to R7. V1 stated V1 thinks V17 was off at 5pm on 8/14/21. V1 stated the conclusion of the investigation was that R7 had increase in behavior and delusions 2020 and R7 was removed from psychiatric services due to refusing them. V1 stated V1 thinks they were looking through the nurse's notes and Medication Administration Record to see if R7 had been taking R7's medications. V1 doesn't believe R7 was taking medications. V1 stated V1 asked V17 about R7's clock and that V17 stated the clock was discussed 2 weeks prior. This is not documented in the investigation. V1 stated V17 returned on V17's next shift but could not remember when that was. 3. The facility's Final Report dated 8/10/21, documents R4 and R11 were the residents involved in the abuse allegation (unidentified type by facility) on 8/6/21. The alleged perpetrator is documented as V19, Housekeeping. V20, staff member (Certified Nursing Assistant) CNA overheard V19 asking R4 and R11 to hurry up and finish so V19 could clear the table. The facility's investigation documents a witness statement from V20, stating V20 overheard V19 telling residents V19 had too much to do to have to come back and clean up their dishes. This statement documents V20 made the mistake of not reporting it this morning but again this afternoon at lunch, (V19) was saying it again in particular to R11. V19 asked R11 if R11 was done (with meal) to which R11 replied R11 was not finished. V19 then said, I (V19) don't have time for this, I'm (V19) not clearing dishes again. V20's statement also documents V21, Physical Therapy Assistant (PTA) came to V20 hearing things V19 was saying, so V20 reported it. There is no documentation of how the facility came to conclusion V19 has a delayed mental disability is or that V19 has one. There is no documentation V19's personnel file was reviewed during the investigation. There is no documentation the facility completed an investigation on the verbal abuse allegation that occurred in the morning of 8/6/21, prior to the verbal abuse allegation on 8/6/21 at lunch time. On 9/29/21 at 12:45pm, V1, Administrator in Training (AIT) stated V1 was unable to find an investigation for the verbal abuse allegation that had occurred the morning of 8/6/21, prior to the lunch time allegation. V1 stated V19 worked until after the verbal abuse allegation on 8/6/21 around lunch time because V20 did not report the verbal abuse allegation from that morning until V20 reported both when it happened around lunch time.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35510 Based on interview and record review, the facility failed to ensure they had sufficient staffing on a 24 hour basis to provide nursing care to all residents in accordance with staffing their Facility Assessment documents the facility needs. This failure has the potential to affect all 36 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] documents the facility has a large percentage of residents with an Alzheimer's or Dementia diagnosis. This assessment documents resident acuity is determined by the physical, cognitive, behavior and medical needs the residents of the facility have. The amount of assistance from staff is calculated including acuity of residents. This assessment documents numbers of staffing are analyzed to ensure there is sufficient staff to meet the needs of the residents at any given time. This staffing plan located in the Facility Assessment shows standard staffing patterns which can be altered to meet the needs of the residents. This assessment documents the number of licensed nurses per shift to meet resident needs as follows: 1st shift (days)- 2 nurses 2nd shift (evening)- 2 nurses 3rd shift (nights)- 1 nurse This assessment documents the number of Certified Nurse Aides (CNA) per shift to meet residents needs as follows: 1st shift(days)- 4 2nd shift (evening)- 3 3rd shift(nights)- 2 The facility's Daily Nursing Staffing sheets document staffing numbers below the analyzed staffing numbers in the Facility Assessment to ensure there is sufficient staff to meet the needs of the residents at any given time. These sheets document the staff numbers that worked as follows: 8/23/21 - One nurse on evenings, one CNA on days 8/24/21 - One nurse on evenings, two CNA's on evenings 8/25/21 - One nurse on evenings 8/26/21 - two CNA's on evenings (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8/28/21 - One nurse on evenings, three CNA's on days 8/29/21 - one nurse on evenings 8/30/21 - two CNA's on days 8/31/21 - three CNA's on days 9/1/21 - one nurse on evenings 9/2/21 - one nurse on evenings, three CNA's on days 9/3/21 - three CNA's on days 9/4/21 - one nurse on evenings 9/5/21 - one nurse on evenings, 2 CNA's on evenings 9/6/21 - three CNA's on days 9/7/21 - one nurse on evenings 9/9/21 - one nurse days and evenings, one CNA on nights 9/10/21 - one nurse on evenings, one CNA on nights 9/11/21 - one nurse on evenings one CNA on nights 9/12/21- one CNA on nights 9/13/21 - One nurse on day, one nurse on evening shift 9/14/21 - one nurse on days, evenings, night shifts, one CNA on nights 9/15/21 - one nurse on evenings, one CNA on nights 9/16/21 - one nurse on evening shift, three CNA's on days and one CNA on nights 9/17/21 - one nurse on evenings, two CNA's on evenings and one CNA on nights 9/18/21 - one nurse on evenings 9/19/21 - one nurse on evenings, three CNA's on days and one CNA on night shift 9/22/21 One nurse on days and evenings, one CNA on nights 9/23/21 - one nurse on days and evenings, three CNA's on days (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/24/21 - one nurse on days and one nurse on evenings, one CNA on night shift 9/25/21 - one nurse on days, three CNA's on days, one CNA on nights 9/26/21 - one nurse on days and one nurse on evenings, three CNA's on days 9/27/21 - one nurse on days and one nurse on evenings 9/28/21 - one nurse on days and evenings and three CNA's on days 9/29/21 - one nurse on days and evenings, three CNA's on days 9/30/21 - one nurse on days and evenings, three CNA's on days 10/1/21 - one nurse on days, three CNA's on days, two CNA's on evenings and one CNA on nights 10/2/21 - one nurse on days and evenings, three CNA's on days 10/3/21 - one nurse on days and evenings, three CNA's on days, two CNA's on evenings. On 9/30/21 at 11:30am, V1, Administrator in Training (AIT) stated the facility is short on nurse staff. V1 stated the facility has been interviewing for nurse and CNA positions. V1 stated the facility usually has two nurses on day shift and 1 nurse on each shift for evenings and nights. V1 states the facility's assessed staffing needs are 2 CNA's for night shift, 4 CNA's for day shift and 3 CNA's for evening shift. V1 stated V1 is unaware of the staffing needs based on the facility assessment. V1 confirmed the amount of staff working is lower than the amount of staff needed and has been that way for a while. The facility's Daily Roster dated 9/21/21 documents 36 residents reside in the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35510 Based on interview and record review, the facility administrative staff failed to recognize an allegation of sexual physical abuse, causing the facility to not complete an investigation for the allegation or report the allegation to the State Survey Agency. This failure affects two residents (R1, R2) reviewed for abuse allegations in the sample of 12. Findings include: R1's Progress Notes dated 9/5/21 at 11:15am document R1 was found next to R2 in a recliner. This note documents V3, Licensed Practical Nurse (LPN) observed R1 attempting to put (R1's) hands on (R2) inappropriately; V3 intervened and separated R1 and R2. V3 notified V16, Regional Director (RD). This note documents will continue to monitor and keep separate from females. The fax notification sheet dated 9/5/21 at 11:49am documents Another resident (R1) attempted to sexually inappropriate touch (R2). On 9/23/21 at 10:10am, V12 (Housekeeper) stated V12 observed R1 dipping (R2's) hand in (R1's) pants. V12 stated R1 kept trying to put R1's hands in/down the front of R2's pants multiple times. V12 stated R1's hand was down (R2's pants) enough to R1's knuckles and was trying to push down further in to R2's pants. V12 stated V12 had not been contacted by V1 (Administrator in Training - AIT) for an interview regarding the incident on 9/5/21. V12 stated R1 was purposefully touching R2 in a sexually inappropriate way and R2 would not be able to consent or know what was happening. On 9/23/21 at 12:05pm V15 (Cook) stated, V15 witnessed R1 and R2 sitting in the oversized recliner with R1's arm around R2 on 9/5/21 just after lunch. V15 stated V15 knew it wasn't right. V15 stated V15 was not contacted for a witness statement for this allegation of abuse. There is no documentation this sexual abuse allegation on 9/5/21 at 11:15am was reported to the State Survey Agency or was investigated thoroughly. On 9/23/21 at 9:42 am V3 (Licensed Practical Nurse-LPN) stated V12 (Housekeeping) witnessed R1 and R2 on 9/5/21 at 11:15 sitting together and that V12 stated, oh look, look where R1's hand is. V3 stated V3 called V16, Regional Director after separating R1 and R2 and explained what happened and that V3 was not sure what to do about the situation. V3 stated V3 did not send a report to public health related to the sexual abuse allegation nor notify the police per direction from V16 because V3 did not see R1 put R1's hand down R1's pants. V16 did not think it was necessary to complete a sexual abuse allegation investigation. V3 stated R1 wandered the facility that afternoon and kept trying to wander down the hall where female residents are located. V3 stated R1 had a history of sexually related comments to staff multiple times in the past. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/21 at 2:30pm, V16 stated V3 notified V16 of the allegation between R1 and R2, stating nothing happened and that is why it was not investigated or reported to the State Survey Agency. V16 stated V16 was unaware V12, Housekeeper and V15, Cook were witnesses to the sexual abuse allegation on 9/5/21 at 11:15am. V16 stated V16 only spoke with V3 although there were additional staff present at the time the incident occurred. V16 stated V16 was unaware V12 witnessed R1's fingers/hand inside R2's pants far enough to the knuckles.