STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145862	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Skilled Nsg & Rehab	910 West Polk Street Charleston, IL 61920

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 - 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** 41970 Based on observation, interview and record review the facility failed to protect the resident's right to be free from sexual abuse by another resident and verbal/mental abuse by a staff member for four of seven residents (R1, R2, R3 and R5) reviewed for abuse in the sample list of seven residents. These failures resulted in R2 crying, feeling uncomfortable, and removing herself from shared areas with R1 after R2 was sexually abused by R1 and R5 experiencing feelings of isolation and fear after a staff member verbally/mentally abused R5. Findings include. 1.) R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 requires staff assistance for transfer into/out of her wheelchair and is able to propel wheelchair independently once seated. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 as independent in bed mobility, transfers, walking less than ten feet and self propels wheelchair for longer distances. R1 and R2's combined Final Incident Report to the State Agency dated 7/8/24 documents (R2) stated (R1) touched her breast in the hallway. On 7/18/24 at 3:50 PM R2 stated R2 was wheeling herself down the hallway when R1 wheeled himself up to R2. R2 stated R1 reached out both of his hands and rubbed up and down on both of R2's breasts firmly several times. R2 stated R1's hands were on the outside of R2's blouse. R2 stated I told him (R1) to stop. I pushed his hands away. I told him that he can't do that. That was embarrassing. I am married. R2 stated R1 said 'I am going to get my yummies' as he was rubbing on R2's breasts. R2 was tearful and crying during interview. R2 was wiping tears away from her cheeks and using tissue to blow her nose. R2 stated R2's husband is very ill. R2 stated I wasn't going to tell my husband but how could I keep that from him. He is my husband. After I told him what (R2) had done, we both cried. We were both so upset about the whole thing. R2 stated They (facility) told me that he wasn't coming back after they sent him to the hospital. But now he is back. I don't want to leave. I want him to leave. If I see (R1), I turn around and go the other way. Now I always have to worry about where he is at. No woman is safe when he is here. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	On 7/19/24 at 1:30 PM V10 Licensed Practical Nurse (LPN) stated R2 reported to V10 on 6/30/24 that R1 had rubbed up and down on R2's breasts and said 'I am going to get my yummies'. V10 stated I called (V2) Director of Nurses (DON) who instructed me to call the police, make all the notifications and put (R1) on continual observations. A few hours later (R1) was sent to the emergency room due to a change of condition not related to his behaviors. On 7/19/24 at 3:42 PM V1 Administrator stated R1 should have never been allowed to inappropriately touch R2. V1 stated Unfortunately, that is considered sexual abuse if both parties are not willing. (R2) was not willing. We (facility) have already started inservicing our staff. 2.) R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. This same MDS documents R3 requires assistance with transfers and is able to propel self in her wheelchair. R1's Nurse Progress Note dated 6/29/24 at 2:58 PM documents (R1) attempting to touch staff and residents inappropriately, stating he is going to touch the female nurses. (R1) stating he wants the nurse to get down on her knees for him. Touching a Certified Nurse Aide (CNA) on their buttocks. (R1) stating all women need a man. Educated (R1) multiple times. Stating (R1) might have to get sent out (emergency room), (R1) stated he doesn't care. R1's Nurse Progress Note dated 6/29/24 at 4:15 PM documents (V1) Administrator notified of (R1) trying to touch staff and residents. (V1) stated to keep (R1) away from women and take two staff into room with (R1) for any care. On 7/19/24 at 10:50 AM R3 stated R3 was wheeling herself towards the exit door at 2:50 PM on 6/29/24. R3 stated I know it was ten until 3:00 PM because I was going out with the smokers. I don't smoke but I like to sit outside a lot. (R1) rolled right up to me and started to grab at my Left Breast. I batted his arms away and he ended up grabbing my arm. That didn't hurt or anything. (R1) just grabbed my arm to stay close to me because he was still trying to grab at my breast. (R1) had his hand cupped when he was grabbing at me. Like it was the shape of my breast. I told him to go away. I told him to stop it and he can't do that. (V13) Certified Nurse Aide (CNA) saw that happen. Well, he went on down the hall and I went outside. As we were coming back inside, I went to the dining room. (R1) rolled up to me in the dining room and tried to do the same exact thing. This was about 3:30 PM. I batted him away again and he left the dining room. I reported that incident also to (V4) LPN. I will not go to the dining room if (R1) is in there. I like activities and I like to talk to people but I will just stay in my room when (R1) is on the loose. I am not scared of (R1) but that made me feel very vulnerable and uncomfortable. It really shook me up. If (R1) is trying to touch women who are alert and oriented, what is he trying to do with those that aren't? On 7/18/24 at 1:50 PM V13 Certified Nurse Aide (CNA) stated V13 witnessed R1 approach R3 in his wheelchair in the hallway. V13 stated R1 attempted to grab at R3's Left Breast and R3 'swatted' R1 away. V13 stated R1 grabbed R3's Left Arm in an attempt to grab at R3's Left Breast. V13 CNA stated both residents (R1, R3) were separated and this incident was reported to V4 Licensed Practical Nurse (LPN). V13 stated R1 was placed on a one to one (continual monitoring) the next day (6/30/24) after R1 touched R2's breasts. On 7/19/24 at 1:25 PM V10 Licensed Practical Nurse (LPN) stated R3 reported to V4 LPN and V10 on 6/29/24 that R1 had attempted to touch her Left Breast in the hallway just before the afternoon smoke break on 6/29/24. V10 stated R3 said R1 did not touch her breast but did attempt to. (continued on next page)

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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 - Actual harm Residents Affected - Few	On 7/19/24 at 3:40 PM V1 Administrator stated V1 never received any calls on 6/29/24. V1 stated V1 did receive a call on 6/30/24 and referred staff to call V2 Director of Nursing (DON). V1 Administrator stated R1 should have been placed on continual observations on 6/29/24 right after the first attempt at inappropriately touching R3's Left Breast. 3.) R5's undated Face Sheet documents R5's medical diagnoses as End Stage Renal Disease, Right Below the Knee Amputation, Diabetes Mellitus Type II with Neuropathy, Chronic Pulmonary Edema, Renal Osteodystrophy, Post Traumatic Stress Disorder and dependence on Renal Dialysis. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. This same MDS documents R5 as dependent on staff for assistance with toileting, dressing, bathing, personal hygiene, transfers and mobility. R5's Electronic Medical Record (EMR) documents R5 utilizes a total body mechanical lift for transfers. On 7/18/24 at 11:45 AM R5 stated A couple of weeks ago (V8) Certified Nurse Aide (CNA) cussed me out like a dog. (V8) told me that if I was going to keep turning on my call light that she would put my f****** a** (expletives) in a chair and make me sit in the f****** (expletive) hallway. (V8) is a night shift CNA that always comes in my room and cusses at me. R5 stated I put on my call light to see if someone could get me a can of soda out of the machine. (V8) Certified Nurse Aide (CNA) came in, turned off my call light. I asked (V8) if she would take my debit card to get me a soda and she refused. Then I asked (V8) if she could get me up so that I could roll down to the vending machine myself and get a soda. (V8) CNA said 'Get up your f****** (expletive) self'. So I said 'OK. I will. I will just crawl down there on my own.' That is when (V8) said 'This ain't no f****** (expletive) hotel. You can get that your f****** (expletive) self. R5 stated R5 is scared of V8 CNA. R5 stated It is just (V8) and me in the middle of the night. I don't want to make her mad because who knows what (V8) will do. (V8) already just left me in my chair. I can't get up on my own. I had to just sit there until the next shift showed up a few hours later. I was afraid to ask (V8) to do anything else that night so I just sat there. On 7/18/24 at 12:15 PM V8 Certified Nurse Aide (CNA) stated V8 regularly cares for R5. V8 CNA stated (R5) asked for a block of cheese one night and I told him no because the kitchen was running out of cheese because of him. (R5) is alert and oriented and repeatedly doesn't follow his orders. (R5) is on Dialysis and just had his lower Right Leg amputated so he needs our help for most things. (R5) is so fat because he just sits around all the time. The last thing (R5) needs is soda and cheese. (R5) knows better and just rings for staff to do everything for him. I am not going to help someone who can do things for themselves. I did refuse to take his Debit card and I told (R5) he didn't need any kind of sodas. (R5) asked me to get him up and I said no because he doesn't need any soda in the middle of the night. (R5) said 'I am going to just crawl there' and I told him 'Go ahead and crawl then. See how far you get.' I don't remember ever using foul language but I did tell (R5) that this wasn't a hotel and he needs to do things for himself instead of bothering the staff. (R5) asks for things he knows he shouldn't have. On 7/19/24 at 3:45 PM V1 stated V8 Certified Nurse Aide (CNA) should have provided the cares R5 requested. V1 Administrator stated (R5) is alert and oriented. If (R5) asks the staff to get him up into his wheelchair, then they should do that. (V8) should never have used any profanity or bad attitude towards (R5). That is not acceptable. (continued on next page)

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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 - Actual harm Residents Affected - Few	The facility policy titled 'Abuse Policy' revised 1/9/24 documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The is facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Sexual Abuse is the non-consensual sexual contact of any type with a resident. Non-consensual is defined as one of the following: 1. The resident may welcome the act, but the resident lacks the ability to consent, 2. The resident does not want the contact, 3. Resident is unconscious/comatose, 4. Resident is sedated. This abuse includes, but is not limited to, unwanted intimate touching of any kind (especially of the breast or perineal area), sexual harassment, sexual coercion, sexual assault such as rape, sodomy, or coerced nudity. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to report an allegation of physical abuse to the Abuse Coordinator timely for two of seven residents (R1, R5) reviewed for abuse in the sample list of seven. Findings include: R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. The facility was not able to provide documentation that R5's allegation of physical abuse between R1 and R5 was ever reported to the Abuse Coordinator and/or the State Agency. On 7/18/24 at 11:45 AM R5 stated A couple of months ago (R1) and I were roommates and we (R1, R5) got into a fist fight. (V8) Certified Nurse Aide (CNA) worked last night and I told her about that. (V8) said she didn't have any control over who my roommate is and I would just have to deal with it. On 7/18/24 at 2:30 PM R1 stated My old roommate (R5) and I didn't get along. We (R1, R5) beat each other up one time. I don't remember when. I never liked him (R5) anyway. I let (R5) have it. On 7/18/24 at 12:15 PM V8 Certified Nurse Aide (CNA) stated (R5) told me last night about that, him and (R1) got into a fist fight the last time they were roommates. (R5) told me he didn't want (R1) as a roommate because they (R1, R5) will probably end up fighting again. On 7/19/24 at 3:50 PM V1 Administrator stated V1 was never informed of an allegation of physical abuse between R1 and R5. V1 stated any allegation of any type of abuse should be reported to V1 Administrator. V1 Administrator stated I am not sure that a fist fight ever happened because I think I would have heard about it. But, the allegation should still have been reported so that I could investigate further. The facility policy titled 'Abuse Policy' revised 1/9/24 documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities to include Illinois Department of Public Health (IDPH), Ombudsman, Local Police Department, Power of Attorney, Physician in a timely manner.

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to protect residents (R2, R3) from inappropriate behaviors and sexual abuse by another resident (R1) after an abuse allegation. This failure affects three of seven residents (R2, R3 and R1) reviewed for abuse in the sample list of seven. This failure resulted R2 crying, feeling uncomfortable, and removing herself from shared areas with R1 after R1 was left unsupervised and R1 sexually abused R2. Findings include: The facility policy titled 'Abuse Policy' revised 1/9/24 documents the facility is committed to protecting residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone. The policy also states the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Sexual Abuse is the non-consensual sexual contact of any type with a resident. Non-consensual is defined as one of the following: 1. The resident may welcome the act, but the resident lacks the ability to consent, 2. The resident does not want the contact, 3. Resident is unconscious/comatose, 4. Resident is sedated. This abuse includes, but is not limited to, unwanted intimate touching of any kind (especially of the breast or perineal area), sexual harassment, sexual coercion, sexual assault such as rape, sodomy, or coerced nudity. 1.) R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 requires staff assistance for transfer into/out of her wheelchair and is able to propel wheelchair independently once seated. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 as independent in bed mobility, transfers, walking less than ten feet and self propels wheelchair for longer distances. R1's Nurse Progress Note dated 6/29/24 at 2:58 PM documents (R1) attempting to touch staff and residents inappropriately, stating he is going to touch the female nurses. Educated (R1) multiple times. Stating (R1) might have to get sent out (emergency room), (R1) stated he doesn't care. On 7/18/24 at 3:55 PM R2 stated R1 rubbed both of his hands over R2's breasts several times on 6/30/24. R2 stated I heard (R1) did something to another resident (R3) the day before he fondled my breasts. They (facility) sent (R1) to the hospital. They (facility) told me that he wasn't coming back. But now he is back. I don't want to leave. I want him to leave. (R1) just roams around. If I see (R1), I turn around and go the other way. Now I always have to worry about where he is at. No woman is safe when he is here. R2 was tearful and crying during the interview. (continued on next page)

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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 0610 Level of Harm - Actual harm Residents Affected - Few	On 7/19/24 at 3:42 PM V1 Administrator stated R1 should have been placed on continual observations on 6/29/24 right after the first attempt at inappropriately touching R3's Left Breast. V1 stated That really put our residents at risk. I was on medical leave that weekend so I was not aware that (R1) was not on continual observations. (R1) should have been (on continuous observations) to help prevent any further incidents from happening. 2.) R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. This same MDS documents R3 requires assistance with transfers and is able to propel self in her wheelchair. On 7/19/24 at 10:50 AM R3 stated R1 attempted twice to touch R3's Left Breast inappropriately on 6/29/24. R3 stated (V13) Certified Nurse Aide (CNA) saw it happen the first time. R3 stated I told (R1) to stay away and not to do that when (R1) tried to touch my breast the first time. Then (R1) wheeled up to me and tried to do it again about 40 minutes later. I think they (staff) should have been watching him closer. R3 stated I will not go to the dining room if (R1) is in there. I like activities and I like to talk to people but I will just stay in my room when (R1) is on the loose. I am not scared of (R1) but that made me feel very vulnerable and uncomfortable. It really shook me up. If (R1) is trying to touch women who are alert and oriented, what is he trying to do with those that aren't? On 7/18/24 at 1:50 PM V13 Certified Nurse Aide (CNA) stated V13 witnessed R1 attempt to grab at R3's Left Breast and R3 'swatted' R1 away. V13 stated R1 grabbed R3's Left Arm in an attempt to grab at R3's Left Breast. V13 stated R1 was placed on a one to one (continual monitoring) the next day (6/30/24) after R1 touched R2's breasts. On 7/19/24 at 3:40 PM V1 Administrator stated V1 never received any calls on 6/29/24. V1 stated V1 did receive a call on 6/30/24 and referred staff to call V2 Director of Nursing (DON). V1 Administrator stated R1 should have been placed on continual observations on 6/29/24 right after the first attempt at inappropriately touching R3's Left Breast. V1 stated residents were at risk of being abused by R1 when the facility was aware that R1 was having inappropriate sexual behaviors and did not send R1 to the emergency room for evaluation and/or place R1 on continual monitoring immediately after the first incident with R3.