

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Iroquois Resident Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Fairman Avenue Watseka, IL 60970	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34201</p> <p>Based on interview and record review, the facility failed to timely report an allegation of sexual abuse to the Administrator for two of three residents (R1, R2) reviewed for sexual abuse on the sample list of three.</p> <p>Findings Include:</p> <p>The facility's Serious Injury Incident and Communicable Disease Report dated 4/10/24 at 12:15 pm documents, on 4/9/24 at 12:45 pm, R2 leaned over and kissed R1 on the lips. Since both R1 and R2 have a very low BIMS (Brief Interview for Mental Status) score; R1 being a 1 {indicating severe cognitive impairments} and R2 being a 4 {indicating severe cognitive impairments}, the intervention in place is to make sure that residents are watched and separated to prevent this from happening again.</p> <p>On 4/17/24 at 11:09 am, V1 (Administrator) stated on 4/10/24, V8 CNA (Certified Nursing Assistant) came up to V1 and asked V1 if V1 was aware of what happened on 4/9/24 between R1 and R2. V1 explained V1 was unaware of anything happening, then V8 reported that V8 had been told that R2 kissed R1. V1 stated V8 did not know any of the specifics though and told V1 to talk to V4 CNA(Certified Nursing Assistant), who was present when it occurred. V1 then questioned V4 and V4 reported that V4 was taking R1 to the restroom on 4/9/24 before lunch, around 11:15 am, when R2 approached R1 and kissed R1 and stated, I'm here now or I'm back, something to that affect. V1 explained R1 was in a wheelchair at that time and that V4 intervened and told R2 that R2 couldn't do that, that it was inappropriate. V1 stated V1 educated V4 that V4 should have reported it immediately to V1 because it is reportable and I (V1) am on a timeline to get things reported. V1 explained that V4 has worked at the facility for a long time, so (V4) should have already known that this would be considered a sexual abuse allegation and should have been reported. V4 reported to V1 that V4 reported the allegation to V10 RN (Registered Nurse) when it happened but when V1 spoke to V10, V10 said that the allegation was never reported to V10.</p> <p>On 4/17/24 at 12:02 pm, V4 CNA stated V4 was taking R1 to the restroom by the Nurses Station when R2 came up behind us and said I'm going to be here and bent over and kissed R2 on the lips. V4 explained V4 told R2 that R2's actions were inappropriate and that R2 couldn't be doing that {kissing R1}. V4 stated V4 reported the incident to V10 RN (Regitered Nurse), because V4 was busy and assumed that V10 would have reported the incident to V1 but V10 didn't. V4 explained, the following day, V1 asked V4 about the incident after being told about it by another CNA.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/24 at 7:49 pm, V10 RN (Registered Nurse) stated V4 did not report the incident of R2 kissing R1 to V10 explaining, if V4 would have, V10 would have immediately reported the incident to V1.</p> <p>The facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy dated 1/4/24 documents any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will then report abuse to the state agency per State and Federal requirements. Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>34201</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of sexual abuse for two of three residents (R1, R2) reviewed for sexual abuse on the sample list of three.</p> <p>Findings Include:</p> <p>The facility's Serious Injury Incident and Communicable Disease Report dated 4/10/24 at 12:15 pm documents, on 4/9/24 at 12:45 pm, R2 leaned over and kissed R1 on the lips. Since both R1 and R2 have a very low BIMS (Brief Interview for Mental Status) score; R1 being a 1 {indicating severe cognitive impairments} and R2 being a 4 {indicating severe cognitive impairments}, the intervention in place is to make sure that residents are watched and separated to prevent this from happening again. The Investigation only contained witness statements from R1, R2, V4 CNA (Certified Nursing Assistant), V3 Secretary, and V10 RN (Registered Nurse). No other residents were interviewed.</p> <p>On 4/17/24 at 11:09 am, V1 Administrator stated the only residents that were interviewed were R1 and R2, the two residents involved in the allegation. V1 stated no other residents were around but now understands that other residents should have been interviewed to see if they have ever had concerns with R2 or if they had ever witnessed R2 displaying inappropriate behaviors.</p> <p>On 4/17/24 at 12:02 pm, V4 CNA(Certified Nursing Assistant) stated V4 was taking R1 to the restroom by the Nurses Station/Dining Room when R2 came up behind us and said I'm going to be here and bent over and kissed R2 on the lips. V4 stated there were several people; staff and residents, in the general location as the incident occurred right before lunch, around 11:15 am.</p> <p>The facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy dated 1/4/24 documents the facility will have written procedures for investigating abuse, neglect, misappropriation, and exploitation that include: identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations to provide a complete and thorough documentation of the investigation.</p>