

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 000	INITIAL COMMENTS	F 000			
F 223 SS=K	<p>Annual Licensure and Certification Survey</p> <p>An extended survey was conducted.</p> <p>483.13(b), 483.13(b)(1)(i) ABUSE</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect and provide interventions for 10 out of 10 known residents sexually abused, (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34) by another resident, (R19). R19 sexually abused these 10 residents from 1-17-2009 through 5-26-2009.</p> <p>These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 6-5-2009, the facility remains out of compliance at a severity level 2. Additional time is needed to monitor the effectiveness of the implementation of abuse policies/ procedures and to complete training for staff.</p> <p>Findings Include:</p> <p>The 4-23-2009 Physician Progress Notes document R19 as having diagnoses of chronic obstructive pulmonary disease, hypertension,</p>	F 223			

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 223	<p>Continued From page 1</p> <p>chronic kidney disease, and sexual behaviors. Additionally this same Physician Progress Note documents, "ambulates independently, has been propositioning and touching female residents. He is being closely monitored."</p> <p>On 6-2-2009 at 10:20am. and 6-3-2009 at 2:30pm. R19 was ambulating independently within the facility. R19 was at times, out of staff's sight.</p> <p>On 6-9-2009 at 11:05am. E11, (RN/Registered Nurse) stated, "I started working here around February 11, 2009. I wasn't given specific information on (R19's) behaviors. I witnessed situations with (R19) on weekends, he favored the ladies. I kept a watchful eye on him. The majority of incidents I witnessed were where (R19) would approach non-verbal females and I would intervene. (R19) would get angry with me. I would put the female by me at the medication cart and (R19) didn't like it. He would say 'who do you think you are' or 'I'm going to get you fired' He didn't like for me to intervene. I don't think it was consensual. I didn't like it. I was uncomfortable. I wouldn't want it to happen to my parents. The residents were non-verbal. (R28) always looked frightened and I saw fear in her eyes. There were no specifics on how to provide interventions to the victims. I observed that (R19) targeted the non-verbal residents. I made sure (R19) saw me, because he would look around to see who was watching."</p> <p>E10, (Social Service Director) completed Risk Assessments for Abuse and Neglect in January 2009 and February 2009 on R2, R8, R9, R18, R21, R25, R27, and R29. E10 documented, on these same Risk Assessments for Abuse and</p>	F 223			

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F 223	<p>Continued From page 2</p> <p>Neglect, all the above identified residents, "High susceptible risk for abuse and neglect."</p> <p>R28's 1-21-2009 Risk Assessment for Abuse and Neglect completed by E10, (Social Service Director) is, "Victim of spousal neglect/abuse. High risk factor as susceptible for emotional/mental or other types of neglect/abuse."</p> <p>R33 on 6-5-2009 at 10:15am. stated, "I have seen (R19) two times touching the breasts of unresponsive residents. (R28's) sister visits, is concerned, and asked me if I would watch (R28) from (R19) and said (R28) is scared to death of (R19). I can't remember the name of the second resident. (R19's) son told me he was going to get some medication to quench his (R19's) sex urges. (R19) has kissed other residents. (R19's) son came over a couple of weeks ago and he's hosted some dinners for us and told a couple of us about his dad. Staff have asked me several times to keep an eye on (R19) to watch him and tell them. His (R19) language is bad. He talks in common areas loudly about his wet dreams and needs sexually. He has a loud voice. I go to my room a lot to not hear that. I hate the F word. This has been going on for some time. It was not consensual between the residents and (R19)."</p> <p>R26 on 6-5-2009 at 10:50am. stated, "(R19's) son asked me to kind of watch over his dad. I've heard him tell (R19) not to do stuff. (R19) knows I'll lay into him if he tries stuff. I'm not afraid of him." (R26 raised her fist and shook it). "So he don't try it on me. I'm safe, I don't know about anyone else."</p> <p>On 6-5-2009 at 10:20am. R25 nodded her head</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>yes to I've been touched inappropriately and stated, "a man did it. I don't know too much, but I hope he's dead. He could be - yes dead."</p> <p>The 1-19-2009 and 4-17-2009 MDS, (Minimum Data Set) documents R19 with socially inappropriate/disruptive behavioral symptoms occurring 4 to 6 times a week, behaviors not easily altered.</p> <p>R19's 1-27-2009 Care Plan Progress Review Verification Notes is, "is exhibiting mood and behaviors that tend to have increased. He has had some socially inappropriate behavior in regards to sexual inhibitions which staff are monitoring. Also is seeing (Z1, Psychiatrist) for this."</p> <p>The 2-12-2009 Care Plan for R19 documents approaches for his Problem of sexual behaviors as "Resident needs to be kept upbeat due to his behaviors. Resident has problems with all females and no males in activities so encourage him to attend in the last five minutes. Allow resident to express himself, never not talk to him. Tell him to come to you at any time."</p> <p>R19's 1-20-2009 Quarterly Social Service Progress Note includes, "Inappropriate sexual 'overture' to female residents. Care Plan addition for sexual behaviors and will schedule with (Z1/Psychiatrist) to assess possibilities, medication, increased risk for female residents, if to dementia wing versus closer supervision."</p> <p>On 6-3-2009 Z1, (Psychiatrist) stated, "I've been seeing (R19) since 11-10-2009. My first notes of sexual behaviors was on 3-26-2009. No history of sexually acting out behaviors were reported to</p>	F 223			

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F 223	<p>Continued From page 4 me until 3-26-2009."</p> <p>R19's 3-26-2009 Psychiatric Progress Note documents the following: Behaviors Manifested: "Overly amorous with ladies."</p> <p>The 3-26-2009 Informed Consent To Use Psychotropic Medication documents R19's Reason for Medication: "Verbal outburst at almost every meal, depressed, sexual advances toward female residents."</p> <p>Nursing Note of 12-24-2008 at 11:30am. is, "Overheard (R19) talking inappropriately to other female residents, attempting to lure these female residents to his room. Social Service notified."</p> <p>R19's 1-18-2009 at 10:00am. Nursing Note is, "observed kissing another resident, attempted to handle her, and go to her room."</p> <p>The 1-25-2009 at 2:00pm. Nursing Note is, "(R19) propositioned another resident to have relations with him."</p> <p>Nursing Notes of 2-15-2009 at 10:00am. and 2:00pm. are, "(R19) talking inappropriately to a female."</p> <p>On 3-18-2009 at 2:00pm. documented nursing note is, "(R19) acting out several times today, yelling, verbally aggressive. 3-18-2009 at 2:30pm. (R19) propositioned another resident for relations. This nurse overheard and intercepted."</p> <p>In addition to the above Nursing Note incidents, four Concern Identification Forms/Witness Interview Forms dated 1-17-2009 through 3-10-2009 document R19 as victimizing R2, R25,</p>	F 223			

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F 223	<p>Continued From page 5 R21, and R27 as follows:</p> <p>On 1-17-2009 E7, (Activities) reported, "I heard (R19) prodding (R25) along saying things such as, come on I, (R19) just want to hold your hand. I (E7) tried to discretely remove (R25) from the situation, but it wasn't working as she was too confused. (R19) tried to get (R25) into his room, stating it's ok, he, referring to (R20, roommate) won't watch."</p> <p>E7, (Activities) reported that on 1-24-2009 at 10:30am. R2 and R19 were kissing. "I, (E7) spoke with (R2) about it and (R2) stated she's never done anything to get with (R19), but that (R19) is making her do it."</p> <p>E8, (CNA/Certified Nursing Assistant) reported on 3-4-2009 at 3:30pm. "I saw (R19) with his hand on (R21's) breast. (R21) screamed and it seemed like she was going to smack (R19). (R19) got very offensive with (Nurse) and started screaming at her, told her she was (fecal material) and was going to speak to the (Administrator)."</p> <p>On 3-10-2009 E10, (Social Service Director) documented, "Nurse saw (R19) grab (R27's) breast. (Nurse) verbally cued (R19) and he responded it's all (fecal material) and mind your own business."</p> <p>E12, (Activities Aide) on 6-9-2009 at 9:35am. stated, "I've been the Activity Aide for about five years. I noticed a change in (R19) in January. I would report what I saw to the nurses. Some nurses told me to write a Concern Form, some said they would document it. The people I wrote Concern Forms on were defenseless. I know</p>	F 223			

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F 223	Continued From page 6 these people didn't like it. I feel (R19) knew what he was doing. (R19) went after dementia patients. The nurses asked me to watch (R19). They'd say he's already been on the women this morning, so watch him. They'd tell me this when I came in the morning. When I would leave for a short time he (R19) would wait until I was gone for moments and put his hands on, or target the dementia women. Sometimes he would pull back when I'd return or tell me to get out. (R19) would target (R8, R9, R27, and R28). Staff line them up, in the lobby, for meal times, three times a day and additional two to six times a day for cares or to be put to bed. (R19) would wait or sit in the lobby and at night there are less staff. Sometimes he would go from the first in line to the next while I was taking care of that person, he'd be at the next. (R19) wouldn't leave the lobby. It made me sick to watch this. I was sad. Who knows what else went on. I was told by nursing redirect (R19) or remove residents. The Social Service Director would only say we have to be more diligent. I am not aware of any meetings with Administration to discuss the incidents. I have a sense of relief, now that (R19) is gone. When you're eighty to have this happen to you. I believe this is on the verge of sex abuse. I'm not aware of any interventions with the women. They did put (R19) on medications. Staff, nurses, CNAs, and Social Service knew about these sexual incidents with (R19) in January. I didn't sleep for nights, two weeks worrying about this. Even with staff around this sex abuse went on. Leaving the women at the desk didn't help. Women are safe now. Before (R19) left no one was safe. It's a shame it went on this long." On 4-17-2009 the Social Service Progress Note	F 223			

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F 223	<p>Continued From page 7</p> <p>is, "Increase in sexually inappropriate actions/words toward female residents, call into consultant for care plan suggestions. (R19) will see (Z1/Psychiatrist) 4-23-2009 with 8 documented incidents, so probably more. (R19) has problems with sexual behavior must monitor his actions toward our female residents. (R19) uses the walker, does move about on his own and where he wishes to go."</p> <p>The 4-20-2009 Sexuality Assessment for R19 identified the following: Expresses an interest or intention in becoming sexually active with a peer. History of sexually inappropriate behavior documents, "excessive number of times at home with second wife." (R19) has demonstrated sexually or inappropriate behavior in facility." Eight out of fifteen additional risk factors have been identified in this same assessment of R19. Summary: "(R19's) sexual advances to female residents is increasing in number and severity. Risks: Violation of private space -> sexual abuse."</p> <p>From 4-17-2009 through 4-25-2009 R19's Nursing Notes document five incidents to female residents of "sexual innuendos, kissing and fondling breasts, kissing, grabbing, inappropriate talking, and exposing self, just squeeze it." Additionally from 4-16-2009 through 4-24-2009 four Concern Identification Forms/Witness Interview Forms document R19 victimizing R18, R28 and two unknown residents with similar behaviors identified above.</p> <p>R19's 4-23-2009 Phychiatric Progress Note documents as follows: Behaviors Manifested: "Increased sexual action, shaking fist, aggressive, threatening, 4-25 kiss breast."</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>Psychiatric Progress Note and Doctor Orders: "Met with patient and sons. Increased sexual behaviors, increased agitation, touching breasts, exposed self, impulsive behavior and comments. Discussed medications."</p> <p>From 4-25-2009 through 5-26-2009 R19's Nursing Notes document eight incidents to female residents of sexual innuendos, sexual inappropriate talk, kissing, fondling breasts, R19's hand between legs and fondling. These same Nursing Notes document R19's response to redirection from Nursing staff as verbally aggressive, angry, yelling, pointing and threatening to have staff fired. The eight Nursing Notes documenting R19's sexual abuse of unknown residents did not contain responses or interventions for the identified incidents other than inconsistent documentation of redirecting R19 or removing the female resident.</p> <p>On 5-20-2009 at 8:15pm. R19's Nursing Notes document, "Sitting in lobby in rocking chair watching television. This nurse walked another resident down to the shower room. When this nurse returned in approximately two minutes later resident was standing over the top of another resident, who is in a wheelchair with his hands down the front of her pants moving his hand around. Resident was redirected away from the resident and (R19) began yelling, swearing, and name calling."</p> <p>E10, Social Service Director on 5-23-2009 documents, "I tallied increased reports since (R19) saw (Z1/Psychiatrist) last (4)."</p> <p>From 4-30-2009 through 5-22-2009 three Concern Identification Forms/Witness Interview</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>Forms document R19 victimizing R8, R9, R29, and R34 with behaviors of kissing, touching/ fondling breasts, hands on lower half of resident's body, sexually inappropriate talking, and allegation of face slapping.</p> <p>The 5-28-2009 Psychiatric Progress Note documents R19 as follows: Behaviors Manifested: "Targets other dementia females, kiss, hand under shirt, down pants, verbal outbursts." Psychiatric Progress Note and Doctor Orders: "Seen for follow-up sexual behaviors, some agitation, verbal outbursts."</p> <p>On 6-5-2009 at 2:30pm. E22, (LPN/Licensed Practical Nurse) stated, "I think R19's behaviors were sexual in nature. Yes, it is sexual abuse when one resident touches another resident's breast without consent, regardless of their cognitive abilities. The incidents I witnessed were not consensual."</p> <p>The 6-5-2009 at 2:23pm. Nursing Note documents that R19 was transported for inpatient hospital evaluation.</p> <p>On 6-5-2009 at 3:25pm. Z2, (Medical Director) stated, "about two or three weeks ago the Administrator called me about (R19's) sexual behaviors. I advised the Administrator to call the Psychiatrist and (R19's) primary care physician. Just yesterday I was told how many residents were involved. In my opinion the women were demented, do not know what was done. I have not been told about all the victims, reporting, and frequency. (R19) is in (acute care facility). The problem has been solved because (R19) is not present."</p>	F 223			

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F 223	<p>Continued From page 10</p> <p>E2, (DON/Director of Nursing) on 6-4-2009 at 2:40pm. stated, "(R19's) sexual overtures with female residents began in January 2009. The CNA, (Certified Nursing Assistants) staff kept coming to me about (R19's) behaviors and asking what to do. I'm wondering if we didn't do enough for the residents. In fact last night we (Administration) discussed did we act appropriately. Did we do enough, so we went and interviewed the residents. We discussed were they victimized and other ladies in the area. I thought, damn I didn't do anything for them, (victims). I might have made wrong choices with (R19), but I don't think so. We have looked at this from (R19's) point of view."</p> <p>On 6-3-2009 Z1, (Psychiatrist) stated, "I agree there are two separate issues, (R19's) behaviors and how to manage these behaviors with other residents." During this same interview Z1 verbalized he saw R19 on 11-10-2009, 3-26-2009, 4-23-2009, and 5-28-2009.</p> <p>As a result of the facility failure to protect and provide interventions, 10 of 10 residents were sexually abused, (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34) by another resident, (R19). On 6-4-2009 an Immediate Jeopardy was identified to have begun on 1-17-2009, with the first documented incident of abuse. Additional incidents of documented abuse occurred through 5-26-2009.</p> <p>On 6-4-2009 at 3:45 p.m, E1, Administrator was informed of the Immediate Jeopardy.</p> <p>The surveyor confirmed through interview and record review the facility took the following actions to remove the Immediate Jeopardy:</p>	F 223			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 223	Continued From page 11 1. 6/4/09 Inservicing conducted by the Director of Nursing regarding Resident Abuse, Behaviors and the care of R19. 2. 6/4/09 Interviews begun with female residents. Interviews conducted by members of the Quality Assessment and Assurance Members. 3. 6/4/09 R19 placed on direct 1:1 supervision with nursing staff. CNA's to document behaviors every 15 minutes. Nurses to chart hourly. 4. 6/4/09 Incident reports initiated for all residents formerly addressed on concern forms. Director of Nursing and Administrator reviewed. 5. 6/5/09 Female resident interview forms completed. Administrator reviewed. 6. 6/5/09 Skin Assessment Forms completed for all residents identified on Concern forms. Administrator reviewed. 7. 6/5/09 All residents identified on Concern forms had care plan's updated. This includes the perpetrator's care plan. Administrator reviewed. 8. 6/5/09 Nurse Consultant onsite to provide oversight for completion of Immediate Jeopardy removal. 9. 6/5/09 Nurse Consultant inserviced department head staff and Administrator on Abuse Prevention, Seven steps to abuse prevention, Accident and Incident investigation policy and procedure, Resident Rights, Concern/Complaint policy and procedure with	F 223			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 223	<p>Continued From page 12</p> <p>abuse prevention post-test. Administrator present additional information investigation and parameters for inservicing the respective departments.</p> <p>10. 6/5/09 Resident Abuse Risk Assessments completed for 100% of residents. Administrator reviewed.</p> <p>11. 6/5/09 Environmental Risk Assessment completed by Environmental Services Director.</p> <p>12. 6/5/09 Quality Assessment and Assurance committee members inserviced respective department employees on Resident Abuse Prevention, Investigation, Policy and Procedure, Seven steps to abuse prevention, Facility Concern/Complaint Policy and Procedure, Incident/Accident Investigation policy and procedure, and Resident Rights.</p> <p>13. 6/5/09 R19 transferred to inpatient psychiatric unit.</p> <p>14. 6/5/09 Quality Assessment and Assurance committee reviewed all incident reports with witness statements and summations.</p> <p>15. 6/5/09 Quality Assessment and Assurance committee re-inserviced on F223, F225, F226, and F490 by Nurse Consultant.</p> <p>16. 6/5/09 Quality Assessment and Assurance committee discussed immediate interventions and assignment of these interventions</p> <p>17. 6/5/09 Schedule for continuous facility monitoring put in place. Managerial staff will be in facility 24 hours per day until notice received</p>	F 223			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 223	Continued From page 13 that Immediate Jeopardy is removed.	F 223			
F 225 SS=K	<p>18. 6/6/09 Quality Assessment and Assurance committee completed and faxed to Illinois Department of Public Health all Abuse reports.</p> <p>19. 6/6/09 Direct supervision and oversight of Administration will be done by Chairman of the Nursing Home committee. External oversight provided by Nurse Consultant.</p> <p>20. 6/6/09 Chairman of Nursing Home Committee, Medical Director, and Nurse Consultant will review all complaint/concerns for immediate follow-up.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 14</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct thorough investigations for 14 reports involving one male resident (R19) sexually assaulting female residents. Administration failed to immediately initiate an investigation after receiving allegations of R19's inappropriate sexual behaviors. This facility failure resulted in R19 continuing his inappropriate sexual advances for a period of six months to 10 different female residents (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34). The facility failed to implement preventative measures to protect 5 of 11 female residents on the selected sample (R2,R8, R9, R18, R21) and 5 female residents outside the sample (R25, R27, R28, R29, and R34) from sexual assault.</p> <p>These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 06-06-09, the facility remains out of</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 225	<p>Continued From page 15</p> <p>compliance at a Severity Level 2 Additional time is needed to monitor staffing ability to implement the Abuse Protocol monitor the effectiveness of the inservices.</p> <p>Findings include:</p> <p>Nurses notes dated 12/24/09 at 11:30 a.m., state that R19 was "talking inappropriately to female residents attempting to lure these female residents to his room. SS (Social Services) notified."</p> <p>On 06/04/09 at 1:30 p.m., E10 (Social Service Director- SSD) verified that the Witness Interview forms dated 01/17/08 and 01/24/08 were incorrectly dated and should have been dated 01/17/09 and 01/24/09. Witness Interview forms, Concern Identification forms and Incident reports from 01/17/09 through 05/26/09 document 15 incidents where R19 was making sexual comments, kissing, fondling female residents' breasts, and/ or groin area.</p> <p>The facility's Abuse Prevention policy, undated, states "sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault." This policy further states that "Once the administrator/ DON (Director of Nurses)/SSD determines there is a reasonable cause for possible mistreatment, the administrator /DON /SSD will investigate or appoint a person to take charge of the investigation."</p> <p>E10 stated, during interview from 1:00 p.m. to 2:40 p.m. on 06/04/09, that she (E10) receives the reports (Facility Concern Identification forms and/or Witness Interview forms) and if any are</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
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F 225	<p>Continued From page 16</p> <p>allegations of abuse, an investigation is started by herself (E10), the Director of Nurses (E2) or the Administrator (E1) who are on the facility's abuse committee. E10 stated that none of the incidents from 01/17/09 - 05/26/09 had been investigated. E10 stated she (E10) had not considered these reports as reports of sexual abuse, but that they were reports of R19's inappropriate behavior.</p> <p>E10 reviewed these reports and confirmed that facility staff used different forms for reporting what they had witnessed. E10 stated that many forms were incomplete with some areas blank and some missing dates and times.</p> <p>Information from individual reports follow:</p> <p>1. Witness Interview form dated 01/07/08 (verified to actually be 01/17/09) completed by E7 (Activity aide) stated that at 7:30 p.m., R19 asked R25 to follow him to his room. E7 states he followed R19 and R25 because of R19's actions the previous day with R2. E7 documented that R19 said "it's okay he (referring to R20) won't watch."</p> <p>On 06/04/09 at 1:00 p.m., E10 stated that this report was on a Saturday and she would have probably received it on Monday. E10 stated R25 had previously come forward with some allegations regarding her roommate, but had never come forward with allegations regarding R19. E10 stated R25 had not been interviewed regarding this report. E10 stated she (E10) is not aware of any investigation involving R19 and R2 "from the previous day", but thought that R19 had been kissing R2. E10 stated that E2 was aware of the 01/17/09 incident and was addressing R19's "inappropriate behavior." E10 stated that</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 17</p> <p>R25 was "not aware of what was going on" and that E7 intervened and separated them. E10 said the plan was to monitor R19.</p> <p>2. Witness report dated 01/24/08 (verified to be 01/24/09) completed by E7, states that at 10:30 a.m., R19 sat next to R2 and was witnessed kissing. E7 writes that he "broke it up" and spoke to R2 who stated that she (R2) had never done anything to get with R19, but he (R19) is making her do it.</p> <p>On 06/04/09 at 1:00 p.m., E10 stated that in January 2009, R19 and R2 were kissing and petting. E10 stated she (E10) talked with R2 who told her, that she (R2) tells him (R19) "no", but he won't stop. E10 stated that R2 is developmentally slow, but was "participating." E10 stated that R2 waits for her husband on weekends and at night in an isolated area. E10 said she told R2 to stay with staff. R2's clinical record included no documentation of this information. E10 confirmed that she had not documented this and provided a note dated 06/04/09 at 11:52 a.m. as a late entry for 01/30/09.</p> <p>On 06/09/09 at 10:00 a.m., R2 stated that R19 had touched her inappropriately 2- 3 months ago. R2 said R19 "approached me in the lobby and said he wanted to have sex with me." R2 said that she told him (R19) "No." R2 stated that R19 said he wanted to kiss her and that she "told him 'no', but he did anyway." R2 stated that several times R19 felt her "down there" pointing to her groin area. R2 said this was not consensual and that she never liked it.</p> <p>Risk Assessment for Abuse and Neglect dated</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 18</p> <p>02/24/09 and signed by E10, states that R2 is "simple and could easily be persuaded. High susceptible risk for abuse/ neglect." Care plan dated 02/05/09 identifies that R2 is at risk with high susceptibility for neglect and/or abuse and instructs staff to "report immediately to administrator or supervisor" and to "investigate: thorough confidential interviews conducted & not limited to residents, employees and visitors"</p> <p>3. There are two Witness Interview forms dated 03/04/09, one completed by E8 (CNA) and one completed by E9 (Licensed Nurse). Both reports state that R19 had his hands on R21's breast. E8 writes that R21 "screamed and it seemed like she (R21) was going to smack him (R19)" Both reports indicate that R19 became loud and agitated when staff intervened.</p> <p>On 06/04/09 during the 1:00 p.m. - 2:40 p.m. interview, E10 stated that after this report she talked with R19 on 03/06/09 (2 days later). R19 denied the incident or stated that he couldn't remember. E10 stated in this instance R21 knew what was happening, didn't like it, and screamed. E10 stated she (E10) did not consider this abuse but considered it R19's "inappropriate behavior" and that he (R19) "picked on someone he shouldn't have. He (R19) shouldn't be touching any of them." E10 stated that after this report she contacted her consultant who provided a care plan for inappropriate behavior of fondling breasts and this was added to R19's care plan. E10 said the consultant also provided a sexual assessment which was completed on R19. E10 stated she had completed an assessment for abuse and neglect on all residents and that all 90 residents are at risk. E10 stated she did not talk with R21 regarding the 03/04/09 incident. E10</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 19</p> <p>stated she (E10) "has an open door policy and if she (R21) had anything she (R21) could come to her (E10)."</p> <p>4. Facility Concern Identification Form dated 03/10/09 completed by E10 states that R19 was seen grabbing R27's breast. The Concern Resolution Form dated 03/10/09 states that E10 called R19's family and "ascertained that family advocated more meds." This form also indicates R19 was placed on the list to see the psychiatrist on his next visit.</p> <p>During the 06/04/09 interview from 1:00 p.m. to 2:40 p.m., E10 stated that R27 is "nonsensical" and "didn't seem upset - didn't know what was going on." E10 stated that R19's "grabbing wasn't rough, but more of a seduction" E10 stated that E2 talked with R19 and R19's family and that facility's focus was on R19's inappropriate behavior, not the idea that it was a resident to resident altercation because R27 wasn't participating.</p> <p>5. Facility's concern Identification Form dated 04/16/09 and completed by E10 states that R18 reported that R19 was touching her breasts before lunch in the hallway. E10 documents that she (E10) empathized with her (R18) for being "startled, surprised, and violated." E10 documents that she shared with R18 that "it's not the first time and staff are monitoring him(R19), his actions, and adjustments are being made to his meds."</p> <p>During the 06/04/09 interview, E10 stated that R18 had reported this incident to two staff who brought R18 to her (E10). E10 stated she did not recall who the two staff were. E10 stated she</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 20</p> <p>called the Ombudsman because in this instance it was a resident not staff who reported it. E10 stated R18 was upset and she (E10) called R18's son. E10 stated the facility considered this a resident to resident altercation.</p> <p>R18's clinical record included no documentation of this incident and E10 confirmed that she (E10) was not sure if she (E10) charted it or not. On 06/03/09 at 2:30 p.m., R18 stated that she had reported R19 to some one, she can't remember who, at the facility. R18 stated that R19 came up to her and started to talk and she thought he was just being friendly. Then "he (R19) said he wanted to feel me up." R18 said "he (R19) tried to touch me - he was a complete stranger - he was going to put his hands on me and I gave him a whack." R18 said, "I felt crummy. Like a piece of dirt on the sidewalk. I'd never been talked to that way in my life. I told him (R19) off - that I'd report him and he (R19) said 'go ahead.' I felt awful. I know this lady and he (R19) is making passes at her (the unknown female resident) and the poor thing can't defend herself." R18 said she saw him (R19) "kissing a woman in the hall at lunch time she was in a wheelchair, not all together mentally, and he (R19) was kissing, kissing, kissing her, then would go back to his chair, then back to kiss her." R18 said this was 1- 2 weeks ago. R18 said "I don't know why he hasn't been kicked out. I don't even look at him. I can't stand to. I was just shocked that there is such a person running loose." R18 stated that she was not consensual with R19 "No. Absolutely not! I didn't know who he (R19) was and if I did I wouldn't have anything to do with him." R18 stated that "so many people don't have their right mind and can be an easy conquest for him (R19). R18 said, "I can't figure out why something hasn't</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 21 been done about him (R19)."</p> <p>6. Facility's Concern Identification Form dated 04/17/09 completed by E12 (Activity Aide) states that R19 was standing by R28's chair, saw E12 watching him and sat down. E12 writes that she went down the hall and when she returned 3 minutes later R19 had his hands down R28's shirt. The facility's Concern Resolution Form completed by E10 and dated 04/17/09 states that R19 saw the psychiatrist on 03/26/09, but will reschedule for next rounds on 04/23/09. E10 writes, "Beneficial that (R19) is following thru w (with) cues to stop."</p> <p>7. An assessment Investigation report dated 04/19/09 states that R19 was "exposing himself to female residents and asking other residents to go to bed with him." This report documents that the physician and R19's family were notified. Under further follow up E10 documents that she called E14 (CNA) regarding this report.</p> <p>8. The concern Identification form dated 04/24/09 states that R19 was grabbing another resident's breast. This form does not identify the resident victim. On 06/04/09 at 2:15 p.m., E10 stated she did not know who the resident victim was and went to get E16 (Certified Nurse Aide - CNA) who had completed this report. E16 arrived at 2:20 p.m. and stated she did not remember who the resident victim was. E10 confirmed she had not investigated the report of R19's sexual assault.</p> <p>9. Witness Interview form dated 04/30/09 completed by E19 states that she (E19) was walking through the lounge and saw R19's hands up R8's shirt with his (R19's) hand on R8's breasts. E19 states she removed R8 from the</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 22</p> <p>situation. On this form under outcome of the incident, E10 writes that R19 had received Deproprovera shot on 04/28/09 and awaiting therapeutic levels. E10 also documents that R19's discharge has been discussed by E2, family and Ombudsman. During the 06/04/09 interview from 1:00 p.m. to 2:40 p.m., E10 stated she did not interview R8 because she (E10) wouldn't have thought that R8 would have been very interviewable. Care plan dated 02/05/09 identifies that R8 is at risk with high susceptibility for neglect and/or abuse and instructs staff to "report immediately to administrator or supervisor" and to "investigate: thorough confidential interviews conducted and not limited to residents, employees and visitors"</p> <p>10. Facility's Concern Identification Form dated 05/07/09, E12 states that she (E12) went down the hall and came back in 5 minutes and saw R19 bent over R29 touching her hands which are on the lower half of her body. On the Concern Resolution form dated 05/07/09, E10 writes, "I am grateful all staff are vigilant to (R19) 's possible inappropriate sexual gestures, but he (R19) is a compassionate, sociable man. this just makes are (our) job tougher as he uses this M-O (method of operation) to make his moves and in his confused state it becomes unclear what his intentions are at times."</p> <p>During interview on 06/04/09 from 1:00 p.m. to 2:40 p.m., E10 states she did not investigate who the staff were caring for her (R29) and did not talk with E12 regarding the report. E10 stated she wanted staff to keep writing down so the facility could keep track of R19's behaviors for the psychiatrist to have a clear understanding of what</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 225	<p>Continued From page 23 was working and what was not working.</p> <p>11. Concern Identification and Concern Resolution Forms dated 05/08/09, document R8 reports that a man slapped her face. E10 documented that she called R8's daughter and checked R8's reality orientation and coherent plausibility.</p> <p>On 06/04/09 from 1:00 p.m. to 2:40 p.m., E10 stated that she (E10) talked with R8, but R8 was not a "good reporter."</p> <p>12. The facility's Concern Identification and Concern resolution Forms for the incident of 05/14/09 state that R19 was bent over R9 kissing her on the lips and holding her hand. E12 documents that she (E12) moved R9 down the hallway. E12 states that R9 "cannot stop (R19). He (R19) has to be watched at all times." E10 documents that the managers have discussed R19's "inappropriate behaviors not considered sexual abuse. He (R19) has dementia and is seeking consensual sex, asking females to go to his rm (room). Altho, some of his (R19's) targets are baffled and unable to report, so, (R19) needs to be watched diligently."</p> <p>On 06/04/09 from 1:00 p.m.-2:40 p.m., E10 stated that she received this report on 05/15/09 and did not interview R9 about R19's sexual assault, that R9 is not interviewable. Care plan dated 02/05/09 identifies that R9 is at risk with high susceptibility for neglect and/or abuse and instructs staff to "report immediately to administrator or supervisor" and to "investigate: thorough confidential interviews conducted & not limited to residents, employees and visitors."</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 24</p> <p>R9's family member stated on 06/09/09 at 10:10 a.m. that R19's sexual assault to R9 "made me sick to my stomach" and that "I couldn't sleep at night for almost 2 weeks, worrying about this."</p> <p>13. Concern Identification Form dated 05/26/09 states that R28's family member had been told by another resident's family that R19 had been kissing R28. On the Concern Resolution Form dated 05/26/09, E10 documents that she thanked the family for letting her (E10) know as the facility is keeping track of R19's behaviors for the psychiatrist's interventions.</p> <p>14. Witness Interview form dated 05/22/09 states that E24 (Licensed nurse) left the lobby for 2 minutes and upon return, R19 was standing over R34, with his (R19's) hands down the front of her (R34's) pants, moving his hand around. An incident form for this sexual assault of 05/22/09 documents that R34's physician and family were not notified until 06/05/09 and this incident report is signed by E24 on 06/08/09. A confidential interview form dated 06/09/09 documents E24's statements regarding the sexual assault of R34 which occurred on 05/22/09 (18 days previous.)</p> <p>E10 stated during interview on 6/4/09 from 1 p.m. to 2:40 p.m. that she (E10) did not interview all residents involved in the abuse incidents, staff working during the time of the incidents, or other potential witnesses. E10 stated that investigations were not completed and that as of 06/04/09 at 2:40 p.m., R19's actions were considered inappropriate behaviors and that the facility had not considered sexual abuse.</p> <p>On 06/09/09 at 2:00 p.m., Z4 (Consultant Nurse) confirmed that the facility had not conducted</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 25</p> <p>thorough investigations of reports of R19's inappropriate sexual advances toward the 10 female residents.</p> <p>On 06/05/09 at 9:15 a.m., E1 (Administrator) stated that the facility would start the process today (06/05/09) to interview residents and complete incident investigations.</p> <p>On 6/4/09 an Immediate Jeopardy was identified. The Immediate Jeopardy was determined to have begun on 12/24/08 when R19 talked inappropriately to female residents, attempted to lure them to his room, and the facility failed to investigate.</p> <p>On 6-4-2009 at 3:45 p.m, E1, Administrator was informed of the Immediate Jeopardy.</p> <p>The surveyor confirmed through interview and record review the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 6/4/09 Inservicing conducted by the Director of Nursing regarding Resident Abuse, Behaviors and the care of R19. 6/4/09 Interviews begun with female residents. Interviews conducted by members of the Quality Assessment and Assurance Members. 6/4/09 R19 placed on direct 1:1 supervision with nursing staff. CNA's to document behaviors every 15 minutes. Nurses to chart hourly. 6/4/09 Incident reports initiated for all residents formerly addressed on concern forms. 	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 26 Director of Nursing and Administrator reviewed. 5. 6/5/09 Female resident interview forms completed. Administrator reviewed. 6. 6/5/09 Skin Assessment Forms completed for all residents identified on Concern forms. Administrator reviewed. 7. 6/5/09 All residents identified on Concern forms had care plan's updated. This includes the perpetrator's care plan. Administrator reviewed. 8. 6/5/09 Nurse Consultant onsite to provide oversight for completion of Immediate Jeopardy removal. 9. 6/5/09 Nurse Consultant inserviced department head staff and Administrator on Abuse Prevention, Seven steps to abuse prevention, Accident and Incident investigation policy and procedure, Resident Rights, Concern/Complaint policy and procedure with abuse prevention post-test. Administrator present additional information investigation and parameters for inservicing the respective departments. 10. 6/5/09 Resident Abuse Risk Assessments completed for 100% of residents. Administrator reviewed. 11. 6/5/09 Environmental Risk Assessment completed by Environmental Services Director. 12. 6/5/09 Quality Assessment and Assurance committee members inserviced respective department employees on Resident Abuse Prevention, Investigation, Policy and Procedure,	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 27 Seven steps to abuse prevention, Facility Concern/Complaint Policy and Procedure, Incident/Accident Investigation policy and procedure, and Resident Rights. 13. 6/5/09 R19 transferred to inpatient psychiatric unit. 14. 6/5/09 Quality Assessment and Assurance committee reviewed all incident reports with witness statements and summations. 15. 6/5/09 Quality Assessment and Assurance committee re-inserviced on F223, F225, F226, and F490 by Nurse Consultant. 16. 6/5/09 Quality Assessment and Assurance committee discussed immediate interventions and assignment of these interventions 17. 6/5/09 Schedule for continuous facility monitoring put in place. Managerial staff will be in facility 24 hours per day until notice received that Immediate Jeopardy is removed. 18. 6/6/09 Quality Assessment and Assurance committee completed and faxed to Illinois Department of Public Health all Abuse reports. 19. 6/6/09 Direct supervision and oversight of Administration will be done by Chairman of the Nursing Home committee. External oversight provided by Nurse Consultant. 20. 6/6/09 Chairman of Nursing Home Committee, Medical Director, and Nurse Consultant will review all complaint/concerns for immediate follow-up.	F 225			
F 226	483.13(c) STAFF TREATMENT OF RESIDENTS	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 226 SS=K	<p>Continued From page 28</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow their Abuse Policies and Procedures for six of the seven components of abuse by another resident, (R19). The facility failed to recognize an abusive situation, failed to train staff, failed to protect victims, failed to thoroughly investigate allegations, failed to provide a response/ intervention, and failed to immediately report allegations of abuse for ten residents, (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34). These incidents occurred from 1-17-2009 through 5-26-2009.</p> <p>These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 6-6-2009, the facility remains out of compliance at a severity level 2. Additional time is needed to monitor the effectiveness of the implementation of abuse policies/procedures and to complete staff training,</p> <p>Findings include:</p> <p>1. Failure to recognize an abusive situation.</p> <p>On 6-2-2009 at 1:29pm. E1, (Administrator) stated, "(R19's) Concern Reports are considered resident to resident altercations not abuse or neglect reports. The Abuse/ Neglect committee</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 29</p> <p>meets as allegations or concerns occur. The committee consists of myself, the DON, (Director of Nursing), and SSD, (Social Service Director)."</p> <p>The undated Abuse Prevention policy indicates that : Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, sexual assault.</p> <p>From 1-17-1009 through 5-26-2009 there are 11 Concern Identification/Witness Interviews documenting R19's sexual victimization of ten known residents, (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34. R19's documented behaviors of these female residents, for the above time frame include kissing, fondling, touching breasts, kissing breasts, sexual innuendos, inappropriate sexual talking, coercion, and exposing himself. From 12-24-2009 through 5-22-2009 there are eighteen Nursing Note entries documenting R19's sexual abuse to unknown residents. The documented Nursing Note entries of R19's behaviors are consistent with those reported in the 11 Concern Identification/Witness Interviews.</p> <p>The facility's undated Abuse Policy lists the following Policy Statement and procedure:</p> <p>"The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This will be done by: Identifying occurrences and patterns of potential mistreatment.</p> <p>C. Pattern Assessment At least quarterly, the Quality Assurance Committee will review Concern Identification Reports, Accident / Incident Reports.....to assess</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 226	<p>Continued From page 30 possible patterns or tends.....that may constitute abuse, neglect, or theft."</p> <p>The facility did not follow their own policy and procedures when they did not track these incidents by R19, but rather reported the incidents with female resident victim known and unknown names, either on Concern Identification/Witness Interviews or in Nursing Notes. Three different Forms were used, some were one page, some double sided. Therefore a pattern was also not identified by Administrative personnel.</p> <p>E22, (LPN / Licensed Practical Nurse) on 6-5-2009 at 2:30pm. stated, "I do not document as a nurse on the Resident's Behavior Monitoring Report. Behaviors I witness or Nurses are charted in Nursing Notes. The Behavior Monitoring Report is CNA tracking."</p> <p>On 6-4-2009 at 11:00am. E1, (Administrator) stated, "The Quality Assurance Committee met last night to discuss (R19's) Concern/Incident Reports and the Survey Teams serious concerns regarding (R19), presented at the Daily Status Meeting. We, the Quality Assurance Team did not discuss this specifically prior to this. It was discussed in some daily meetings."</p> <p>On 6-5-2009 at 3:25pm. Z2, (Medical Director) stated, "I come here quarterly, every three months for Quality Assurance Meetings. About two or three weeks ago the Administrator called me about (R19's) sexual behaviors. I advised the administrator to call the Psychiatrist and (R19's) primary care physician. Just yesterday I was told how many residents were involved. In my opinion the women were demented, do not</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 31</p> <p>know what was done. I have not been told about all the victims, reporting, and frequency."</p> <p>Z1, (Ombudsman) on 6-5-2009 at 1:30pm. stated, "I received a call from (R18) and E10, (Social Service Director) regarding (R19's) sexual behaviors. There were more issues. On 4-22-2009 I met with (R19's) son and E10. Staff stressed (R19's) mental status. I have a resident at risk, therefore the perpetrator isn't the question, or his motive. The issue is the resident's safety. I feel the facility could have identified the abuse and should have done more, which might have prevented more sexual abuse."</p> <p>2. Failure to train staff.</p> <p>The facility's undated Abuse Policy indicates under Facility Procedures/Orientation and Training of Employees: "How to assess, prevent and manage aggressive, violent and / or catatropic reactions of residents in a way that protects both residents and staff. On a periodic basis, supervisory personnel will receive training on their obligations under law when receiving an allegation of abuse."</p> <p>Interviews with staff indicate that the facility failed to have on-going training for abuse.</p> <p>Z4, (Nurse Consultant) on 6-9-2009 at 2:05pm. stated, "I did a training for Administrative staff on abuse a couple of years ago. I re-inserviced them last Friday, 6-5-2009."</p> <p>On 6-9-2009 at 11:05am. after asked if Administrative staff trained on interventions for managing abusive situations, including managing</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 32</p> <p>perpetrators and victims, E11, (RN/Registered Nurse) responded, "Maybe in orientation, but no specifics on how to manage perpetrators or victims."</p> <p>E12, (Activities) on 6-9-2009 at 9:35am. stated, "No meetings or training to discuss incidents or what to do." E12 was referring to witnessed incidents of sexual abuse reported to staff involving six known residents, (R19, R2, R9, R8, R28, and R29) beginning in January of 2009. "There is a mandatory training this Friday, June 12, 2009."</p> <p>3. Failure to protect, provide a response/intervention to residents.</p> <p>The facility's undated Abuse Policy outlines that: "Residents who allegedly mistreated 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 and employees of the facility."</p> <p>The facility failed to investigate each documented incident as a possible abuse and did not develop interventions to ensure that the abuse was not on-going.</p> <p>The 4-23-2009 Physician Progress Notes document R19 as having diagnoses of chronic obstructive pulmonary disease, hypertension, chronic kidney disease, and sexual behaviors. Additionally this same Physician Progress Note is, "ambulates independently, has been</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 226	<p>Continued From page 33</p> <p>propositioning and touching female residents. He is being closely monitored."</p> <p>On 6-2-2009 at 10:20am. and 6-3-2009 at 2:30pm. R19 was ambulating independently within the facility. R19 was at times, out of staff's sight.</p> <p>E10, (Social Service Director) completed Risk Assessments for Abuse and Neglect in January 2009 and February 2009 on R2, R8, R9, R18, R21, R25, R27, and R29. E10 documented, on these same Risk Assessments for Abuse and Neglect, all the above identified residents, "High susceptible risk for abuse and neglect."</p> <p>R28's 1-21-2009 Risk Assessment for Abuse and Neglect completed by E10, (Social Service Director) is, "Victim of spousal neglect/abuse. High risk factor as susceptible for emotional/mental or other types of neglect/abuse."</p> <p>From 1-17-1009 through 5-26-2009 there are 11 Concern Identification/Witness Interviews documenting R19's sexual victimization of ten known residents, (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34. R19's documented behaviors of these female residents, for the above time frame include kissing, fondling, touching breasts, kissing breasts, sexual innuendos, inappropriate sexual talking, coercion, and exposing himself. From 12-24-2009 through 5-22-2009 there are eighteen Nursing Note entires documenting R19's sexual abuse to unknown residents. R19's behaviors are consistent with those reported in the 11 Concern Identification / Witness Interviews.</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 34</p> <p>The eighteen Nursing Notes documenting R19's sexual abuse of unknown residents did not contain responses or interventions/measures for the identified incidents other than inconsistent documentation of redirecting R19 or removing the female resident.</p> <p>These same 11 Concern Identification/Witness Interviews when reviewed by E10, (Social Service Director) document E10's response or intervention/measure which does not address the victim or perpetrator. Some examples of such are as follows:</p> <p>Incident of 3-4-2009 at 3:30pm. of R19 grabbing R21's breast: E10, (SSD / Social Service Director) documented 3-6-2009, (two days later) "I had a 1:1 with (R19) to ascertain his issues, complaints. He, (R19) denied or didn't remember about incident. He, (R19) claimed no woman could compare to his wife, and I asked him to remember that. (Z1 / Psychiatrist) to see him second round."</p> <p>Incident of 3-10-2009 of R19 grabbing R27's breast: E10, (SSD) documented 3-10-2009, "I called (R19's) son regarding (R19's) behaviors. He ascertained that family advocated more medication.</p> <p>Incident of 4-16-2009 of R19 touching R18's breast: E10, (SSD) documented 4-16-2009, "I empathized with her, (R18) for being surprised, startled, and then violated. I shared with her, (R18) it's not the first time and staff are monitoring him, (R19).</p> <p>Incident of 4-17-2009 of R19 having his hands down R28's shirt: E10, (SSD) documented,</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 226	<p>Continued From page 35</p> <p>4-17-2009 "Saw (Z1 / Psychiatrist) 3-26, but reschedule (R19) on next rounds, 4-23. Beneficial that (R19) is following through with cues to stop."</p> <p>Incident of 5-7-2009 of R19 bent over R29 with hands on lower half of body: E10, (SSD) documented 5-7-2009, "I am grateful all staff are vigilant to (R19's) possible [inappr] <sic> sexual gestures, but he is also a compassionate, sociable man. This just makes our job tougher, as he, (R19) uses this M-O (method of operation) to make his moves and in his confused state it becomes unclear what his intentions are at times."</p> <p>Incident of 5-8-2009 of R8 alleging R19 slapped her face: E10, (SSD) documented 5-8-2009, "I called (R8's) daughter to let her know we investigate and check (R8's) reality orientation and coherent plausibility. Especially if, (R8) tells her daughter these accusations when she visits."</p> <p>R18 on 6-3-2009 at 2:30pm. stated, "he, (R19) tried to touch me up there, (motioned to her chest area), he was a complete stranger. I felt crummy. Like a piece of dirt on the sidewalk. I'd never been talked to like that in my life. I felt awful." R18 then talked about other incidents she had witnessed with residents she knew and didn't know. R18 then stated, "I don't know why he, (R19) hasn't been kicked out. I don't even look at him. I can't stand to. I can't figure out why something hasn't been done about him."</p> <p>On 6-9-2009 at 2:05pm. E2, (DON/Director of Nursing) stated, "Residents were removed from the situation and (R19) was redirected when</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 36 incidents occurred."</p> <p>Z1, (Psychiatrist) on 6-3-2009 at 2:45pm. stated, "I am the consulting Psychiatrist. The facility Administration did not disclose the victims names to me. Some are probably already patients of mine. I could be and would follow-up on the reported incidents (R19) committed with residents."</p> <p>E2, (DON/Director of Nursing) on 6-4-2009 at 2:40pm. stated, "(R19's) sexual overtures with female residents began in January 2009. The CNA, (Certified Nursing Assistants) staff kept coming to me about (R19's) behaviors and asking what to do. I'm wondering if we didn't do enough for the residents. In fact last night we (Administration) discussed did we act appropriately. Did we do enough, so we went and interviewed the residents. We discussed were they victimized and other ladies in the area. I thought, damn I didn't do anything for them, (victims). I might have made wrong choices with (R19), but I don't think so. We have looked at this from (R19's) point of view."</p> <p>4. Failure to thoroughly investigate and report allegations.</p> <p>From 1-17-1009 through 5-26-2009 there are 11 Concern Identification / Witness Interviews documenting R19's sexual victimization of ten known residents, (R2, R8, R9, R21, R25, R27, R28, and R29). These reports are incomplete, lacking names of witnesses, victims, dates, times, locations. The reports also inconsistently document interventions, outcomes, who reporting to, if family or physician's were notified,</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 226	<p>Continued From page 37 resolutions, and interviews of involved residents were not completed.</p> <p>On 6-3-2009 at 2:40pm. E2, (DON) stated, "Last night we (Administration) discussed did we act appropriately, did we do enough, so we went and interviewed the residents. We wanted to make sure we addressed the other ladies. We sent the one incident of 4-16-2009 involving (R19) and (R18) to Public Health. We did not report the other incidents to Public Health."</p> <p>The facility's undated Abuse Prevention Policy indicates that: "All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential mistreatment to supervisor or the administrator. Such reports will.....be thoroughly investigated. The nursing staff is additionally responsible for reporting on a facility incident report.....as they occur. Upon report of such occurrences, the nursing supervisor is also responsible for assessing the resident, reviewing the documentation and reporting to the Administrator or designee."</p> <p>This same policy outlines that: "If, during the course of an incident investigation, the Administrator/ DON/SSD has determined that there is reasonable cause to suspect mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed immediately."</p> <p>As a result of the facility failure to follow their Abuse Policies and Procedures for six of the seven components of abuse, 10 out of 10 residents, (R2, R8, R9, R18, R21, R25, R27,</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 226	<p>Continued From page 38</p> <p>R28, R29, and R34) were sexually abused by (R19). These incidents occurred from 1-17-2009 through 5-26-2009. On 6-4-2009 an Immediate Jeopardy was identified to have begun on 1-17-2009, with the first documented incident of abuse. Additional incidents of Nursing Note documented abuse occurred through 5-26-2009.</p> <p>On 6-4-09 at 3:45 p.m. E1 was informed of the Immediate Jeopardy.</p> <p>The surveyor confirmed through interview and record review the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 6/4/09 Inservicing conducted by the Director of Nursing regarding Resident Abuse, Behaviors and the care of R19. 6/4/09 Interviews begun with female residents. Interviews conducted by members of the Quality Assessment and Assurance Members. 6/4/09 R19 placed on direct 1:1 supervision with nursing staff. CNA's to document behaviors every 15 minutes. Nurses to chart hourly. 6/4/09 Incident reports initiated for all residents formerly addressed on concern forms. Director of Nursing and Administrator reviewed. 6/5/09 Female resident interview forms completed. Administrator reviewed. 6/5/09 Skin Assessment Forms completed for all residents identified on Concern forms. Administrator reviewed. 	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 39</p> <p>7. 6/5/09 All residents identified on Concern forms had care plan's updated. This includes the perpetrator's care plan. Administrator reviewed.</p> <p>8. 6/5/09 Nurse Consultant onsite to provide oversight for completion of Immediate Jeopardy removal.</p> <p>9. 6/5/09 Nurse Consultant inserviced department head staff and Administrator on Abuse Prevention, Seven steps to abuse prevention, Accident and Incident investigation policy and procedure, Resident Rights, Concern/Complaint policy and procedure with abuse prevention post-test. Administrator present additional information investigation and parameters for inservicing the respective departments.</p> <p>10. 6/5/09 Resident Abuse Risk Assessments completed for 100% of residents. Administrator reviewed.</p> <p>11. 6/5/09 Environmental Risk Assessment completed by Environmental Services Director.</p> <p>12. 6/5/09 Quality Assessment and Assurance committee members inserviced respective department employees on Resident Abuse Prevention, Investigation, Policy and Procedure, Seven steps to abuse prevention, Facility Concern/Complaint Policy and Procedure, Incident/Accident Investigation policy and procedure, and Resident Rights.</p> <p>13. 6/5/09 R19 transferred to inpatient psychiatric unit.</p> <p>14. 6/5/09 Quality Assessment and Assurance</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 226	Continued From page 40 committee reviewed all incident reports with witness statements and summations. 15. 6/5/09 Quality Assessment and Assurance committee re-inserviced on F223, F225, F226, and F490 by Nurse Consultant. 16. 6/5/09 Quality Assessment and Assurance committee discussed immediate interventions and assignment of these interventions 17. 6/5/09 Schedule for continuous facility monitoring put in place. Managerial staff will be in facility 24 hours per day until notice received that Immediate Jeopardy is removed. 18. 6/6/09 Quality Assessment and Assurance committee completed and faxed to Illinois Department of Public Health all Abuse reports. 19. 6/6/09 Direct supervision and oversight of Administration will be done by Chairman of the Nursing Home committee. External oversight provided by Nurse Consultant. 20. 6/6/09 Chairman of Nursing Home Committee, Medical Director, and Nurse Consultant will review all complaint/concerns for immediate follow-up.	F 226			
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 250	<p>Continued From page 41</p> <p>by: Based on record review and interviews, the facility failed to provide and maintain the highest practicable physical, mental and psychosocial well being for 10 of 10 sampled victims who were sexually abused by R19 (R2, R25, R21, R27, R18, R28, R8, R29, R9 and R34.)</p> <p>Findings include:</p> <p>In review of the Facilities complete medical records for R2, R25, R26, R21, R27, R18, R28, R8, R29, R9, R34 from 12/24/08 to 06/09/09, not less than 13 incidents of sexual abuse were documented. Surveyor team has recorded not less than 15 incidents with some victims having not been identified by the facility. Review of these written reports lists no Plan of Action by the facility for support of the victims. The facility has not provided counseling, support, medication adjustment and or discharge to hospital for evaluation for any of the victims.</p> <p>1. R25 on 01/17/09 was observed being lead by R19, away from a safe area, i.e. day room with multiple residents to an isolated area i.e. resident bedroom where she would be more vulnerable and at risk for sexual abuse. No plan or intervention was provided for the victim. From the Witness interview form dated 01/24/08 (sig. 09) R2 was being kissed by R19. "He was making her do it." No plan or intervention was provided for the victim.</p> <p>2. From the Witness interview form dated 01/24/08 (sig. 09) R2 was being kissed by R19. "He was making her do it." No plan or intervention was provided for the victim.</p>	F 250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 250	Continued From page 42 3. From the Witness interview form dated 03/04/09 R21 was observed being abused by R19. " With his hands on her breasts." No plan or intervention was provided for the victim. 4. From the Witness interview form dated 03/10/09, R27 had R19 grab her breasts. No plan or intervention was provided for the victim. 5. From the Concern Identification form dated 04/16/09, R18 stated "He (R19) told me to keep my chin up as he rubbed his hand over both breasts." No plan or intervention was provided for the victim. 6. From the Witness interview form dated 04/17/09 R19 was observed grabbing her (R28) breasts. E10 social Service director stated 06/04/09 at 02:00 PM that "The intervention for her was to tell her to call the Ombudsman." 7. Per Assessment Investigation Report dated 04/19/09, R19 was observed exposing his penis to residents. A list of the victims was not available by the facility. Interviews with staff were not successful in identifying these residents. No plan or intervention was provided for these victims. 8. From the Concern Identification form dated 04/24/09 R19 was witnessed by staff grabbing the breasts of unidentified female residents. A list of the victims was not available by the facility. Interviews with staff were not successful in identifying these residents. No plan or intervention was provided for these victims. 9. From the Witness interview form dated 04/30/09, R8 was observed by staff being fondled	F 250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 250	<p>Continued From page 43</p> <p>by R19, "hands down shirt fondling breasts". No plan or intervention was provided for the victim.</p> <p>10. From the Concern Identification form dated 05/06/09 R19 "bent over R29 with his hands on hers which were on her lower half of her body." No plan or intervention was provided for the victim.</p> <p>11. From the Concern Identification form dated 05/08/09 R8 alleged that she was slapped on the face by a resident. Concern Resolution Form dated 05/08/09 " Nurse assumed (it was) R19. No plan or intervention was provided for the victim.</p> <p>12. From the Concern Resolution Form dated 05/14/09, R9 was observed with R19 "kissing her on the lips and holding her hand". No plan or intervention was provided for the victim.</p> <p>13. From the Concern Identification form dated 05/26/09, Concern over R19 "kissing" R28. No plan or intervention was provided for the victim.</p> <p>14. From 1-17-1009 through 5-26-2009 there are 13 Concern Identification / Witness Interviews documenting R19's sexual victimization of ten known residents, (R2, R8, R9, R21, R25, R27, R28, R29, and R34. R19's documented behaviors of these female residents, for the above time frame include kissing, fondling, touching breasts, kissing breasts, sexual innuendos, inappropriate sexual talking, coercion, and exposing himself. From 12-24-2009 through 5-22-2009 there are eighteen Nursing Note entries documenting R19's sexual abuse to unknown residents. R19's behaviors are consistent with those reported in the 11 Concern</p>	F 250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 250	Continued From page 44 Identification / Witness Interviews. E2, Director of Nursing stated on 06/09/09 at 02:05 PM, "We were looking at it from R19's position, his behaviors. We didn't address it from the victim's perspective." E10 social Service director stated 06/04/09 at 02:00 PM that "The only intervention we have done for any of these victims was for R28 and that was to tell her to call the Ombudsman."	F 250			
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 356	Continued From page 45 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview and record review, for seven of seven days the facility failed to include the facility name or the resident census with the publicly posted statutorily mandated staffing data. The findings include: Observations and records reviewed for 06/01/09, 06/02/09, 06/03/09, 06/04/09, 06/05/09, 06/08/09 and 06/09/09 showed the document did not include the resident census or the facility name as required by Federal guidelines. When the staffing posting error was presented to E3, Assistant Director of Nursing 06/09/09 at 02:00PM she stated, "We have not been doing this correctly. I have reviewed the Federal guidelines and we will make the necessary corrections. "	F 356			
F 490 SS=L	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 46</p> <p>review the facility administrative staff failed to effectively administer the facility to prevent repeated occurrences of sexual abuse. Administrative staff designated as the Abuse Committee (Administrator, Director of Nursing, and Social Service Director) failed to implement the facility's abuse prevention policy; failed to keep all residents free from sexual abuse; failed to identify sexual abuse and failed to ensure that all staff were knowledgeable about identification, reporting and documentation of abuse. Despite repeated incidents of sexual abuse by R19 to ten residents (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34), Administrative staff designated as the Abuse Committee failed to develop and implement a specific behavior management plan to prevent other residents from being abused. These failures have the potential to impact all 96 residents in the facility.</p> <p>These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 6/6/09, the facility remains out of compliance at a severity level 2. Additional time is needed to monitor the effectiveness of the training and inservices for Administrative staff, as well as the implementation of the policies.</p> <p>Findings include:</p> <p>On 6-2-2009 at 1:29pm. E1, (Administrator) stated, "The Abuse / Neglect committee meets as allegations or concerns occur. The committee consists of myself, the DON, (Director of Nursing), and SSD, (Social Service Director). (R19's) Concern Reports are considered resident to resident altercations not abuse or neglect reports."</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 47</p> <p>The facility's Abuse Prevention policy, undated, states "sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault." This policy further states that "Once the administrator/ DON (Director of Nurses)/SSD determines there is a reasonable cause for possible mistreatment, the administrator /DON /SSD will investigate or appoint a person to take charge of the investigation.</p> <p>E10 (Social Service Director) stated, during interview from 1:00 p.m. to 2:40 p.m. on 06/04/09, that she (E10) receives the reports (Facility Concern Identification forms and/or Witness Interview forms) and if any are allegations of abuse, an investigation is started by herself (E10), the Director of Nurses -DON (E2) or the Administrator (E1) who are on the facility's abuse committee.</p> <p>From 1-17-1009 through 5-26-2009 there are 11 Concern Identification/Witness Interviews documenting R19's sexual victimization of ten known residents, R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34. R19's documented behaviors involving these female residents, for the above time frame include kissing, fondling, touching breasts, kissing breasts, sexual innuendos, inappropriate sexual talking, coercion, and exposing himself.</p> <p>E10 stated during interview on 6/4/09 from 1 p.m. to 2:40 p.m. that none of the incidents from 01/17/09 - 05/26/09 had been investigated. E10 stated she (E10) had not considered these reports as reports of sexual abuse, but that they were reports of R19's inappropriate behavior.</p> <p>These reports as done were incomplete, lacking</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 48</p> <p>names of witnesses, victims, dates, times, locations. The reports also inconsistently documented interventions, outcomes, who reporting to, if family or physician's were notified, resolutions, and interviews of involved residents were not completed.</p> <p>These same 11 Concern Identification/Witness Interviews document E10's (Social Service Director) response or intervention/measure. E10's response does not address the victim or perpetrator and does not provide specific interventions to ensure that the abuse would not continue.</p> <p>Examples follows:</p> <p>Incident of 3-4-2009 at 3:30pm of R19 grabbing R21's breast: There are two Witness Interview forms dated 03/04/09, one completed by E8 (CNA) and one completed by E9 (Licensed Nurse). Both reports state that R19 had his hands on R21's breast. E8 writes that R21 "screamed and it seemed like she (R21) was going to smack him (R19)" Both reports indicate that R19 became loud and agitated when staff intervened.</p> <p>On 06/04/09 during the 1:00 p.m. - 2:40 p.m. interview, E10 stated that after this report she talked with R19 on 03/06/09 (2 days later). R19 denied the incident or stated that he couldn't remember. E10 stated in this instance R21 knew what was happening, didn't like it, and screamed. E10 stated she (E10) did not consider this abuse but considered it R19's "inappropriate behavior" and that he (R19) "picked on someone he shouldn't have." "He (R19) shouldn't be touching any of them." E10 stated that after this report she</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 49</p> <p>contacted her consultant who provided a care plan for inappropriate behavior of fondling breasts and this was added to R19's care plan. E10 said the consultant also provided a sexual assessment which was completed on R19. E10 stated she had completed an assessment for abuse and neglect on all residents and that all 90 residents are at risk. E10 stated she did not talk with R21 regarding the 03/04/09 incident. E10 stated she (E10) "has an open door policy and if she (R21) had anything she (R21) could come to her (E10)."</p> <p>Incident of 3-10-2009 of R19 grabbing R27's breast: E10 documented 3-10-2009, "I called (R19's) son regarding (R19's) behaviors. He ascertained that family advocated more medication."</p> <p>During the 06/04/09 interview from 1:00 p.m. to 2:40 p.m., E10 stated that R27 is "nonsensical" and "didn't seem upset - didn't know what was going on." E10 stated that R19's "grabbing wasn't rough, but more of a seduction" E10 stated that E2 talked with R19 and R19's family and that facility's focus was on R19's inappropriate behavior, not the idea that it was a resident to resident altercation because R27 wasn't participating.</p> <p>Incident of 4-16-2009 of R19 touching R18's breast: E10 documented 4-16-2009, "I empathized with her, (R18) for being surprised, startled, and then violated. I shared with her (R18), it's not the first time and staff are monitoring him, (R19)."</p> <p>During the 06/04/09 interview, E10 stated that R18 had reported this incident to two staff who</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 50</p> <p>brought R18 to her (E10). E10 stated she did not recall who the two staff were. E10 stated she called the Ombudsman because in this instance it was a resident not staff who reported it. E10 stated R18 was upset and she (E10) called R18's son. E10 stated the facility considered this a resident to resident altercation. R18's clinical record included no documentation of this incident. E10 confirmed that she (E10) was not sure if she (E10) charted it or not.</p> <p>On 06/03/09 at 2:30 p.m., R18 stated that she had reported R19 to some one, she can't remember who, at the facility. R18 stated that R19 came up to her and started to talk and she thought he was just being friendly. Then "he (R19) said he wanted to feel me up." R18 said "he (R19) tried to touch me - he was a complete stranger - he was going to put his hands on me and I gave him a whack." R18 said, "I felt crummy. Like a piece of dirt on the sidewalk. I'd never been talked to that way in my life. I told him (R19) off - that I'd report him and he (R19) said 'go ahead.' I felt awful. I know this lady and he (R19) is making passes at her (the unknown female resident) and the poor thing can't defend herself." R18 said she saw him (R19) "kissing a woman in the hall at lunch time she was in a wheelchair, not all together mentally, and he (R19) was kissing, kissing, kissing her, then would go back to his chair, then back to kiss her." R18 said this was 1- 2 weeks ago. R18 said "I don't know why he hasn't been kicked out. I don't even look at him. I can't stand to. I was just shocked that there is such a person running loose." R18 stated that she was not consensual with R19 "No. Absolutely not! I didn't know who he (R19) was and if I did I wouldn't have anything to do with him." R18 stated that "so many people</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 51</p> <p>don't have their right mind and can be an easy conquest for him (R19). R18 said, "I can't figure out why something hasn't been done about him (R19)."</p> <p>Incident of 4-17-2009 of R19 having his hands down R28's shirt: E10 documented, 4-17-2009 "Saw (Z1/ Psychiatrist) 3-26, but reschedule (R19) on next rounds, 4-23. Beneficial that (R19) is following through with cues to stop."</p> <p>Facility's Concern Identification Form dated 04/17/09 completed by E12 (Activity Aide) states that R19 was standing by R28's chair, saw E12 watching him and sat down. E12 writes that she went down the hall and when she returned 3 minutes later R19 had his hands down R28's shirt</p> <p>Incident of 5-7-2009 of R19 bent over R29 with hands on lower half of body: E10 documented 5-7-2009, "I am grateful all staff are vigilant to (R19's) possible [inappr] <sic> sexual gestures, but he is also a compassionate, sociable man. This just makes our job tougher, as he, (R19) uses this M-O (method of operation) to make his moves and in his confused state it becomes unclear what his intentions are at times."</p> <p>During interview on 06/04/09 from 1:00 p.m. to 2:40 p.m., E10 states she did not investigate who were the staff caring for her (R29) and did not talk with E12 regarding the report. E10 stated she wanted staff to keep writing down so the facility could keep track of R19's behaviors for the</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 52</p> <p>psychiatrist to have a clear understanding of what was working and what was not working.</p> <p>Incident of 5-8-2009 of R8 alleging R19 slapped her face: E10 documented 5-8-2009, "I called (R8's) daughter to let her know we investigate and check (R8's) reality orientation and coherent plausibility. Especially if, (R8) tells her daughter these accusations when she visits."</p> <p>From 12-24-2009 through 5-22-2009 there are eighteen Nursing Note entries documenting R19's sexual abuse to unknown residents. The documented Nursing Note entries of R19's behaviors are consistent with those reported in the 11 Concern Identification/Witness Interviews.</p> <p>The facility did not track these incidents by R19, but rather reported the incidents with female resident victim known and unknown names, either on Concern Identification/Witness Interviews or in Nursing Notes. Three different forms were used, some were one page, some double sided. Names of the female victims were not always recorded. Therefore a pattern was also not identified by Administrative personnel.</p> <p>The eighteen Nursing Notes documenting R19's sexual abuse of unknown residents did not contain responses or interventions/measures for the identified incidents other than inconsistent documentation of redirecting R19 or removing the female resident.</p> <p>E2, (DON / Director of Nursing) on 6-4-2009 at 2:40pm. stated, "(R19's) sexual overtures with female residents began in January 2009. The</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 53</p> <p>CNA, (Certified Nursing Assistants) staff kept coming to me about (R19's) behaviors and asking what to do. I'm wondering if we didn't do enough for the residents. In fact last night we (Administration) discussed did we act appropriately. Did we do enough, so we went and interviewed the residents. We discussed were they victimized and other ladies in the area. I thought, damn I didn't do anything for them, (victims). I might have made wrong choices with (R19), but I don't think so. We have looked at this from (R19's) point of view."</p> <p>On 6-9-2009 at 2:05pm. E2, (DON/Director of Nursing) stated, "Residents were removed from the situation and (R19) was redirected when incidents occurred."</p> <p>On 6-4-2009 at 11:00am. E1, (Administrator) stated, "The Quality Assurance Committee met last night to discuss (R19's) Concern/Incident Reports and the Survey Teams serious concerns regarding (R19), presented at the Daily Status Meeting. We, the Quality Assurance Team did not discuss this specifically prior to this. It was discussed in some daily meetings."</p> <p>The facility did not present a complete investigation for any of the alleged incidents. E1 stated 06/05/09 at 09:15 AM "We have not done investigations for these events involving him (R19) as they were behaviors. As of today we will begin interviewing all people involved and do thorough investigations."</p> <p>On 6-5-2009 at 3:25pm. Z2, (Medical Director) stated, "I come here quarterly, every three months for Quality Assurance Meetings. About two or three weeks ago the Administrator called</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
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F 490	<p>Continued From page 54</p> <p>me about (R19"s) sexual behaviors. I advised the administrator to call the Psychiatrist and (R19's) primary care physician. Just yesterday I was told how many residents were involved. In my opinion the women were demented, do not know what was done. I have not been told about all the victims, reporting, and frequency."</p> <p>On 6-2-2009 at 10:20am. and 6-3-2009 at 2:30pm. R19 was ambulating independently within the facility. R19 was at times, out of staff's sight.</p> <p>On 6-9-2009 at 11:05am. E11, (RN/Registered Nurse) stated, "I started working here around February 11, 2009. I wasn't given specific information on (R19's) behaviors. I witnessed situations with (R19) on weekends, he favored the ladies. I kept a watchful eye on him. The majority of incidents I witnessed were where (R19) would approach non-verbal females and I would intervene. (R19) would get angry with me. I would put the female by me at the medication cart and (R19) didn't like it. He would say who do you think you are or I'm going to get you fired. He didn't like for me to intervene. I don't think it was consensual. I didn't like it. I was uncomfortable. I wouldn't want it to happen to my parents. The residents were non-verbal. (R28) always looked frightened and I saw fear in her eyes. There were no specifics on how to provide interventions to the victims. I observed that (R19) targeted the non-verbal residents. I made sure (R19) saw me, because he would look around to see who was watching."</p> <p>E10, (Social Service Director) completed Risk Assessments for Abuse and Neglect in January 2009 and February 2009 on R2, R8, R9, R18,</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
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F 490	<p>Continued From page 55</p> <p>R21, R25, R27, and R29. E10 documented, on these same Risk Assessments for Abuse and Neglect, all the above identified residents, "High susceptible risk for abuse and neglect."</p> <p>R33 on 6-5-2009 at 10:15am. stated, "I have seen (R19) two times touching the breasts of unresponsive residents. (R28's) sister visits, is concerned, and asked me if I would watch (R28) from (R19) and said (R28) is scared to death of (R19). I can't remember the name of the second resident. (R19's) son told me he was going to get some medication to quench his (R19's) sex urges. (R19) has kissed other residents. (R19's) son came over a couple of weeks ago and he's hosted some dinners for us and told a couple of us about his dad. Staff have asked me several times to keep an eye on (R19) to watch him and tell them. His (R19) language is bad. He talks in common areas loudly about his wet dreams and needs sexually. He has a loud voice. I go to my room a lot to not hear that. I hate the F word. This has been going on for some time. It was not consensual between the residents and (R19)."</p> <p>E12, (Activities Aide) on 6-9-2009 at 9:35am. stated, "I've been the Activity Aide for about five years. I noticed a change in (R19) in January. I would report what I saw to the nurses. Some nurses told me to write a Concern Form, some said they would document it. The people I wrote Concern Forms on were defenseless. I know these people didn't like it. I feel (R19) knew what he was doing. (R19) went after dementia patients. The nurses asked me to watch (R19). They'd say he's already been on the women this morning, so watch him. They'd tell me this when I came in the morning. When I would leave for a short time he (R19) would wait until I was gone</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 56</p> <p>for moments and put his hands on, or target the dementia women. Sometimes he would pull back when I'd return or tell me to get out. (R19) would target (R8, R9, R27, and R28). Staff line them up, in the lobby, for meal times, three times a day and additional two to six times a day for cares or to be put to bed. (R19) would wait or sit in the lobby and at night there are less staff. Sometimes he would go from the first in line to the next while I was taking care of that person, he'd be at the next. (R19) wouldn't leave the lobby. It made me sick to watch this. I was sad. Who knows what else went on. I was told by nursing redirect (R19) or remove residents. The Social Service Director would only say we have to be more diligent. I am not aware of any meetings with Administration to discuss the incidents. I have a sense of relief, now that (R19) is gone. When you're eighty to have this happen to you. I believe this is on the verge of sex abuse. I'm not aware of any interventions with the women. They did put (R19) on medications. Staff, nurses, CNAs, and Social Service knew about these sexual incidents with (R19) in January. I didn't sleep for nights, two weeks worrying about this. Even with staff around this sex abuse went on. Leaving the women at the desk didn't help. Women are safe now. Before (R19) left no one was safe. It's a shame it went on this long."</p> <p>On 4-17-2009 R19's Social Service Progress Note is, "Increase in sexually inappropriate actions/words toward female residents, call into consultant for care plan suggestions. (R19) will see (Z1/Psychiatrist) 4-23-2009 with 8 documented incidents, so probably more. (R19) has problems with sexual behavior must monitor his actions toward our female residents. (R19)</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2009
FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER LASALLE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL 61350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 57</p> <p>uses the walker, does move about on his own and where he wishes to go."</p> <p>From 4-17-2009 through 4-25-2009 R19's Nursing Notes document five incidents to female residents of "sexual innuendos, kissing and fondling breasts, kissing, grabbing, inappropriate talking, and exposing self, just squeeze it." Additionally from 4-16-2009 through 4-24-2009 four Concern Identification Forms / Witness Interview Forms document R19 victimizing R18, R28 and two unknown residents with similar behaviors identified above.</p> <p>From 4-25-2009 through 5-26-2009 R19's Nursing Notes document eight incidents to female residents of "sexual innuendos, sexual inappropriate talk, kissing, fondling breasts, R19's hand between legs and fondling." In addition to these same Nursing Notes document R19's response to redirection from Nursing staff as verbally aggressive, angry, yelling, pointing and threatening to have staff fired."</p> <p>The 6-5-2009 at 2:23pm. Nursing Note states that (R19) was transported for inpatient hospital evaluation.</p> <p>On 6-5-2009 at 3:25pm. Z2, (Medical Director) stated, "about two or three weeks ago the Administrator called me about (R19's) sexual behaviors. I advised the administrator to call the Psychiatrist and (R19's) primary care physician. Just yesterday I was told how many residents were involved. In my opinion the women were demented, do not know what was done. I have not been told about all the victims, reporting, and frequency. (R19) is in (acute care hospital). The problem has been solved because (R19) is not</p>	F 490			

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F 490	<p>Continued From page 58 present."</p> <p>Due to Administrative staff's failures to implement policies and procedures for abuse, failure to recognize abuse, and failure to effectively manage facility resources, sexual abuse occurred for 10 residents. On 6/4/09, an Immediate Jeopardy was identified to have begun on 12/24/08 when the facility failed to immediately initiate an investigation after receiving allegations of R19's inappropriate sexual behaviors. This failure resulted in R19 continuing his inappropriate sexual advances for a period of 6 months.</p> <p>On 6/4/09 at 3:45 p.m., E1 was informed of the Immediate Jeopardy.</p> <p>The surveyor confirmed through interview and record review the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 6/4/09 Inservicing conducted by the Director of Nursing regarding Resident Abuse, Behaviors and the care of R19. 6/4/09 Interviews begun with female residents. Interviews conducted by members of the Quality Assessment and Assurance Members. 6/4/09 R19 placed on direct 1:1 supervision with nursing staff. CNA's to document behaviors every 15 minutes. Nurses to chart hourly. 6/4/09 Incident reports initiated for all residents formerly addressed on concern forms. Director of Nursing and Administrator reviewed. 	F 490			

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F 490	Continued From page 59 5. 6/5/09 Female resident interview forms completed. Administrator reviewed. 6. 6/5/09 Skin Assessment Forms completed for all residents identified on Concern forms. Administrator reviewed. 7. 6/5/09 All residents identified on Concern forms had care plan's updated. This includes the perpetrator's care plan. Administrator reviewed. 8. 6/5/09 Nurse Consultant onsite to provide oversight for completion of Immediate Jeopardy removal. 9. 6/5/09 Nurse Consultant inserviced department head staff and Administrator on Abuse Prevention, Seven steps to abuse prevention, Accident and Incident investigation policy and procedure, Resident Rights, Concern/Complaint policy and procedure with abuse prevention post-test. Administrator present additional information investigation and parameters for inservicing the respective departments. 10. 6/5/09 Resident Abuse Risk Assessments completed for 100% of residents. Administrator reviewed. 11. 6/5/09 Environmental Risk Assessment completed by Environmental Services Director. 12. 6/5/09 Quality Assessment and Assurance committee members inserviced respective department employees on Resident Abuse Prevention, Investigation, Policy and Procedure, Seven steps to abuse prevention, Facility Concern/Complaint Policy and Procedure,	F 490			

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F 490	<p>Continued From page 60</p> <p>Incident/Accident Investigation policy and procedure, and Resident Rights.</p> <p>13. 6/5/09 R19 transferred to inpatient psychiatric unit.</p> <p>14. 6/5/09 Quality Assessment and Assurance committee reviewed all incident reports with witness statements and summations.</p> <p>15. 6/5/09 Quality Assessment and Assurance committee re-inserviced on F223, F225, F226, and F490 by Nurse Consultant.</p> <p>16. 6/5/09 Quality Assessment and Assurance committee discussed immediate interventions and assignment of these interventions</p> <p>17. 6/5/09 Schedule for continuous facility monitoring put in place. Managerial staff will be in facility 24 hours per day until notice received that Immediate Jeopardy is removed.</p> <p>18. 6/6/09 Quality Assessment and Assurance committee completed and faxed to Illinois Department of Public Health all Abuse reports.</p> <p>19. 6/6/09 Direct supervision and oversight of Administration will be done by Chairman of the Nursing Home committee. External oversight provided by Nurse Consultant.</p> <p>20. 6/6/09 Chairman of Nursing Home Committee, Medical Director, and Nurse Consultant will review all complaint/concerns for immediate follow-up.</p>	F 490			