STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	**1701 EAST MAIN URBANA, IL 61801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS Surveyor: 13582 300.695(b)(3) 300.695(c)(1) 300.695(c)(5) 300.1010(h) 300.1210(a) 300.3240(a) 300.3240(b) 300.3240(e) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the follow situations: -Sexual abuse of a resident by a staff member, another resident, or a visitor. The facility shall develop and implement a policy concerning local law enforcement notification,	F9999		

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F9999	Continued From page 23 including: -Ensuring the safety of residents in situations requiring local law enforcement notification -Facility investigation of the situation The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a Long-Term Care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.	F9999		

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F9999	Continued From page 24 These requirements are not met as evidenced by: Based on interview and record review in one of one abuse investigations reviewed, facility staff failed to intervene immediately on behalf of the resident (R3), in a presumed sexual abuse incident. This failure allowed the alleged perpetrator to continue to have unwitnessed and proximate access to the alleged cognitively impaired, totally dependent victim. Also, the alleged perpetrator of sexual abuse continued to have access to other similar residents in the facility. Additionally, the alleged victim was not examined by nursing staff until nearly 28 hours after the report of the alleged abuse. The failure to intervene and report resulted in more than 24 hours passing before a criminal investigation could be started; and resulted in an extended delay in R3 being examined by a physician. Furthermore, the facility failed to investigate an allegation made against the same suspect in regards to a weapon being brought into the facility some months earlier. Findings include: Review of R3's most recent Physician's order sheet dated June of 2004, indicates R3 is an 82 year old female resident with a diagnosis of Alzheimers Disease, and shows a Physician's Order for "both bedrails up ...". Review of R3's most recent Minimum Data Set (MDS) dated 4/8/04 reflects R3 is severely cognitively impaired and requires total assist for activities of daily living. Record review of a facility document identified as an incident report, and transmitted via facsimile to the regional office of the State Survey and Certification agency on 6/20/04 at 11:05 AM,	F9999		

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F9999	Continued From page 25 shows R3 was the subject of an alleged sexual abuse that took place on 6/19/04 at 1:45 AM. The report states, "Allegation of possible sexual abuse reported by a CNA (Certified Nurses Assistant). Family and MD (Medical Doctor) informed - nurse suspended. Followup will be completed w/i (within) 5 days." The report also states,"send to (Hospital Emergency Room) on 6/20/04 at 9:45 AM." Review of a hospital document labeled as "Medical/Forensic Documentation Form - Page 4" with R3's name and dated 6/20/04 at 9:51 AM, show the results of a forensics exam completed on 6/20/04 (over 24 hours after the initial report of suspected sexual abuse). The report states "Difficult exam Pt (patient) had no understanding procedure explained.[sic] general findings WNL (within normal limits). External genitalia no tears noted. Small areas of redness noted to 1100 (11 O'clock position) and 600 (6 O'clock position) no speculum exam complete. Anal exam no tears noted to external unable to dilate anus." The report was signed by the examining health professional (Z2). Interview with E1, Certified Nurses Assistant (CNA) on 6/24/04 at approximately 2:20 PM in the Facility Administrative Offices indicates she (E1) was witness to a presumed sexual assault on R3. The CNA states, "Friday, the 18th (June 2004) I came into work. We were on "C" wing. Me , (E3 CNA) and (E4 CNA). (E7), Licensed Practical Nurse (LPN) was the nurse. It was a normal night until (E6 Registered Nurse RN) and (E8, RN) were looking for (E7, LPN)...They (E6 and E8) went walking around looking for him (E7). Also used Walkie Talkies to look for (E7)- could not find him. Me (E1 CNA) and (E4 CNA) were sitting at the	F9999		

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F9999	Continued From page 26	F9999		

table closer to the front hallway talking when (R2's) alarm (personal safety alarm) went off and I responded (at about 1:45 AM), (R2) is (R3's) roommate. I went down there (the room lights were out/no nightlight, nothing). I flipped on the light and looked right at (R2). (R2) was sitting straight up halfway out of the bed. (R2's) bed is by the door. That is when I heard the sound of metal clanking/clinking (the sound of a belt buckle) and the rustle of clothing (like someone was adjusting clothing). I knew what that sound was right away. When I looked up I saw (R3) (on the bed) from the rear down. She was naked from the waist down. No (incontinent brief) on and the siderail was down. (R3) was curled up in a fetal position. She is not able to take off her own (incontinence brief) or put her own siderail down. Something did not look right or sound right. The curtain was pulled halfway. I looked down and saw (E7's) shoes and pants. At that point I realized (E7) was behind the curtain. I told (R2) I needed to get her chair (wheelchair) to take her to the bathroom. I was very afraid at that point. I announced it out loud so he (E7) would know I was going to walk over and get (R2's) wheelchair. When I went to get the chair I got a full view of (E7). He is still not saying a word to me. (E7) turned his head and looked over his shoulder at me and he was adjusting his belt. I pulled the (wheel)chair over there and I was trying to stay cool. I started to put (R2) in the chair and (E7) came over and asked me if I needed help with her. I did not look up at him. I said 'I got it if she cooperates', but he helped me anyway...."

The following quote from E1on 6/24/04 at approximately 2:20 PM in the Facility Administrative Offices shows no intervention by (E1 CNA) on behalf of R3 after presumed abuse is

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F9999	Continued From page 27	F9999		

identified. It also shows (E7 LPN) was allowed to continue to be alone with R3. E1 states, "I took (R2) into the bathroom and (E7) closed the bathroom door. I told him (E7) the nurses were looking for him. When I came out of the bathroom in 5-10 minutes, he (E7) was gone. I looked straight at (R3) and she was on her back with the covers pulled up neatly under her chin."

Interview on 6/24/04 at approximately 2:20 PM in the Facility Administrative Offices, shows E1 describing the unfolding events of 6/19/04. (The CNA states that after she put R2 back to bed she left the room) "I saw (E7 LPN), (E6 RN), and (E8 RN) talking by the nurses station. I heard (E8 RN) questioning him (E7 LPN) about where he had been. (E7 LPN), (E8 RN), and (E6 RN) (then) left. (E1 CNA admits she did not report to the nurses about the alleged abuse before the nurses left the area.) I told (E3 CNA) and (E4 CNA) what happened. I told (E5 LPN Charge Nurse) at approximately 2:30 AM. (E5 LPN) freaked and said 'He'll (meaning E7 LPN) kill us all' From 5:30 AM when we started getting residents up until (E7 LPN) went home sometime after 6:53 AM, (E7) was free to go into resident's rooms by himself."

Review of a facility document identified as R7 LPN's time card show R7 clocked out at 7:07 AM on 6/19/04. This same document shows R7 was not scheduled for work on 6/20/04.

Interview with E5 LPN Charge Nurse on 6/29/04 at approximately 9:00 AM confirms the account of E1 CNA. E5's account shows that E1 CNA reported to her, the charge nurse, at about 2:30 AM and E5 Charge Nurse reported the allegation to the nursing supervisor E6 at approximately 3:00 AM

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F9999	Continued From page 28 on 6/19/04. "I was working the night of 6/19/04-6/20/04. I started my shift at 10:30 PM... When I came back from break, this was about 2:35 - 2:40 AM (E1 CNA) was waiting for me at the end of the hallway by the nurses station. She said she had something to talk to me about. We went into the bathroom and shut the door. (E1 CNA) said we were looking for (E7 LPN) and I heard (R2) yelling and her alarm was going off. So she (E1) went down there and turned the light on. The privacy curtain between A and B bed was pulled some. She (E1 CNA) glanced over and saw (E7 LPN). R3's siderail was down, her (incontinence brief) was off, and she was on her side with her buttocks toward (E1). She said (E7's) back was to her and she heard a sound like he was fixing his belt and the rustling of clothing. She (E1) then started to take (R2) to the bathroom. (E7) then pulled the curtain back and asked if he could help (E1). (E1) said no. She (E1) took (R2) in the bathroom and (E7 LPN) shut the bathroom door. (E1) said she stayed in the bathroom with (R2) until (R2) had toileted. Then she brought (R2) back out and noticed that (R3) was on her back, the cover up nice and neat, and the siderail was up...I was in shock. I have worked with (E1 CNA) since she started and I trust what she says 100%. I totally believed what she told me. I said to (E1 CNA), 'you have to be careful cause (E7) talks about guns alot.' He is always talking about shooting people. (E7) always scared me. He gave me the willys. By then 10-15 minutes had gone by, it would have been 2:45 or 2:50 AM. At about 3:00 AM I went down to the supervisor's office. I then told (E6 Nursing Supervisor). (E6) just stared at me, a look of shock and disbelief. I reiterated, '(E6) I'm serious' (E6) has somewhat of a language problem but I have no doubt she understood. I said'	F9999		

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F9999	Continued From page 29 (E6) you need to do something, you need to call someone' Then I left to go pass 4:00 AM meds. After the med pass (E6) called me and asked if (R3) had any treatments. After she (E6) called me about the treatments nothing else was said. I came back in Saturday night (6/19/04). I found out that (E6) had not done anything. I then badgered her the entire night that she had to call (E13 Director of Nurses). I was relentless. So finally that morning (6/20/04) she called... (E7 LPN) had direct responsibility for (R3) that night. I was honestly afraid and that is why I did not go and examine (R3) {after the suspected abuse was reported.} I did not say anything to (E6 Nursing Supervisor) about examining (R3). She (E6) has been here 20 years, I would have thought that was something she would have known to do. (E8) is also a supervisor-but I did not think about going to (E8). I thought (E6) was going to take care of things..." Interview with E6 Nursing Supervisor on 6/24/04 at approximately 11:20 AM per telephone, confirm she was notified of the abuse allegation but did nothing initially. The Nurse states, {The following is a verbatim quote} "(E1 CNA) told me (R3's) roommate (R2) bed alarm went off. The CNA went into the room. She saw the nurse standing by the closet. (R3) was standing by (the) window. The privacy curtain was closed half-way, one of the bedrails was down. She said the nurse (E7) had his zipper down or she heard the zipper or something. She didn't say whether (R3) had clothes on or not. I was thinking I needed to investigate- I don't know. I first learned of the incident at 5:00 AM on Saturday morning. (E5 LPN Charge Nurse) told me on Saturday morning at 5:00 AM. I have had inservices on abuse, neglect,	F9999		

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F9999	Continued From page 30 and mistreatment. I did not think of the accusation as being abuse." In the course of the investigation it was found that a number of staff were aware of an incident that took place back in October or November of 2003. This incident involved (E7 LPN) bringing a handgun into the facility and showing it to a CNA in a resident's bathroom. The interviews with some staff suggests this incident established an intimidation factor and had an impact on their willingness to report the sexual abuse and to follow the facility policy. {The following is a verbatim quote from E1 CNAon 6/24/04 at approximately 2:20 PM} "(E12 former CNA) used to work here, said (E7) had brought a gun into the facility. Said it to me (E1), (E9 CNA) and someone else. Also (said it to) (E10 CNA) and (E11 LPN). If (E2 Administrator) would have asked me if (E7) had brought a gun into work I would have told him what I was told. That is, he (E7) did bring a gun into the building." {The following is a verbatim quote from E5 LPN Charge Nurse on 6/29/04 at approximately 9:00 AM} "I know awhile back (E14 CNA) said (E7 LPN) had brought a gun into the building and showed it to (E12 former CNA). I can't remember when she told me but it was before this incident. I was told that (E12 CNA) told the Administrator in his exit interview." Review of a facility document titled, "Interview with (E7 LPN)" and dated 6/21/04 shows the following: "...I then asked (E7 LPN) about the rumor that he had brought a gun to work. I stated that during the course of the investigation it was brought up by a	F9999		

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couple of C.N.A.'s that he had brought a gun to work. (E7 LPN's answer) Sigh, yes I did about 7 to 8 months ago. Probably was a stupid thing and I suppose you will fire me for that now, but I am an antique gun collector and I brought it for another CNA to see that also was interested in guns. Once I knew he was not coming in that night, I took my backpack back out to my vehicle. I asked if it was loaded. No, I guess I am stupid but not that stupid. I then reminded (E7) of our policy on weapons and that it was never appropriate to bring a handgun to any place of work but specifically (the facility)..."

Interview with (E12 former CNA) on 6/25/04 at approximately 4:40 PM per telephone, confirms E7's admission that E7 brought a gun into the facility. The former CNA states, "I reported that (E7) brought a gun into the facility over a year ago. I told the Human Resources person during my exit conference (interview). He (E7) pulled me into the bathroom of a resident's room and pulled a gun out and showed me."

Interview with E15 Human Resources Director on 6/29/04 at approximately 11:30 AM shows E12 former CNA did inform the facility of someone bringing a weapon into the facility. E15 states, "I did an exit interview with (E12) in the fall of 2003, October or November. (E12) told me in the interview that he was being sexually harassed by his female co-workers...He did say that people brought weapons to work. I (E15) said guns and he (E12) said no. Then I went down the list, I said knifes, he (E12) said no."

Interview with E2 Administrator on 6/30/04 at approximately 3:00 PM confirmed he was notified

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F9999	Continued From page 32 by E15 Human Resources Manager that E12 had reported during an exit interview that an employee had brought a weapon into the facility. When asked if he had conducted an investigation into the allegation E2 said "no". E2 also verified that the Police were never called. Record review of a facility document titled "Employee Disciplinary Record" and dated June 24, 2004 shows E7 LPN was discharged from service for conduct. That conduct detailed under "Employer Remarks : Employee was accused of sexual misconduct with a resident on June 19, 2004. In addition, in the course of the investigation, this employee was accused of bringing a hand gun to work. After further investigation, the employer is terminating employment with this employee due to sexual abuse and for admitting to bringing a weapon (hand gun) to the workplace. Either offense alone is cause for termination." Review of a copy of a facility document titled, "Employee Disciplinary Record" with the name of E6 RN Nursing Supervisor as the employee and dated 6/24/04 show E6 being terminated for the failure to report the alleged abuse incident. The form reads, "This employee was notified of a sexual abuse allegation at approximately 3:30 AM June 19,2004. This employee was notified on multiple occasions by a charge nurse and the reporting C.N.A. between 3:30am on June 19th and June 20th before she properly notified the Director of Nursing at 7:00am on June 20th, of an abuse allegation. Employee violated facility's abuse protocol by not initiating the investigation timely."	F9999		