STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145866	A. BUILDING _____ B. WING _____	C 03/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY NURSING PAVILION	**9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457**

(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 STATE FINDINGS ASSOCIATED WITH THIS SURVEY: 300.690 a) 300.690 a) 1) 300.690 a) 2) 300.690 c) 300.1010 h) 300.1220b) 3) 300.3240 a) 300.3240 b) 300.3240 c) 300.3240 d) 300.3240 f) The facility shall notify the Department of Public Health of any incident or accident which has, or is likely to have, a significant effect on the health, safety or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department¿s toll-free complaint registry number. A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven (7) days of the	F9999		

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F9999	Continued From page 11 occurrence. The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. Facility staff 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, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician¿s plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. The DON shall supervise and oversee the nursing services of the facility, including: Developing an up-to-date resident care plan for each resident based on the resident¿s comprehensive assessment, individual needs and goals to be accomplished, physician¿s orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident¿s condition. The plan shall be reviewed at least every three months. 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.	F9999		

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F9999	Continued From page 12 A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident¿s representative. A facility administrator who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident¿s condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These regulations were not met based on the Facility¿s failure to: 1.) Follow their Abuse Prevention Program for 2 residents in the facility, R2 and R3. 2.) Supervise and protect R2 after facility became aware of a witnessed incident involving R3 being sexually aggressive towards R2. 3.) Initiate an investigation when the incident was reported. 4.) Update the care plan for R3 to indicate new approaches and interventions for his escalating behaviors. These failures resulted in R3 twice entering the room of R2 during the early morning hours of 03/23/05 and attempting to sexually assault her. Findings include: R2 is a 42 year old female with diagnoses	F9999		

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F9999	Continued From page 13 including paranoid schizophrenia, seizure disorder and a history of drug and alcohol abuse. R3 is a 37 year old male resident with diagnoses including head injury from blunt trauma and poor impulse control related to organic brain syndrome . R3 also has a documented history of inappropriate sexual behavior towards female residents and staff. During surveyor interview with R2's roommate, R 6, on Friday 03/25/05, R6 stated that on Wednesday, 03/23/05, at approximately 5AM, she was awoken by R2 yelling out "stop that hurts". R6 said she got out of her bed, went around to the other side of the privacy curtain and saw R3 standing over R2. When R3 saw R6 , he left the room. R6 stated that she asked R2 if she was okay and she said yes. Approximately 30 minutes later R2 began yelling again and when R6 got up to investigate she again saw R3 standing over R2. R3 again left the room when he saw R6 standing there. R6 said she didn't call the nurse right away because she was scared but when E5 (CNA) came in the room she told her. Surveyor asked R6 who else she reported the incident to and R6 stated that she told E1 (social worker), E2 (night shift nurse), and E3 (director of nurses). When R6 was asked when she told these staff members she stated that she told them that same morning, (03/23/05). R6 also told surveyor that she was surprised to see R3 in the building because everyone (staff) had reassured her that they would get him (R3) out of there. R6 also told surveyor that she is scared and feels responsible for protecting R2. Surveyor interviewed R2 and asked her what	F9999		

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F9999	Continued From page 14 happened and she stated, "That R3 (stated R3's first name) guy bothers me, I don't know what is going on." R2 stated that R3 has been coming in her room and bothering her. She stated that he took his "you know what" out, got on top of her and touched her all over. R2 further stated she is afraid of R3 because he wouldn't listen to her when she told him to leave her alone and she doesn't know what he could be doing to her when she is sleeping. R2 also stated that another resident touched her one time and when she told him to stop he left her alone but R3 has something wrong with him and won't listen and he might do this to someone else. Surveyor asked E1 who he reported the incident to. E1 said that it was discussed at the morning meeting so everyone knew about it. E1 documented the incident in the record and wrote that he called the family of R3 to come and get him for the weekend to give him a "change of scenery". Surveyor reviewed the facility's incident log and found no report of the incident. E6 (administrator) admitted that the incident was never reported, the police were not called, the physician was not notified and there were no steps taken to protect R2 from R3 after the incident occurred. E3 (DON) was interviewed and stated that she was at the meeting when the incident was being discussed but it did not sound that serious to her. Surveyor interviewed R3 who denied going into R 2's room. R3 stated that he only went to that side of the building to use the bathroom because there was someone in the bathroom on his side. R3's room is located on the opposite side of the entry to the facility and is not next to R2's room.	F9999		

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F9999	Continued From page 15 The bathrooms are located in the hallways on both sides of the building. Review of R3's medical record found Nurses notes which reflected that on 02/09/05 R2 alleged that R3 pinched her on the buttocks. When questioned by staff about the incident, R3 denied the allegation and stated that he was attempting to help her out of the bathroom. E1's social services note dated 02/10/05 stated that R3 walked in on R2 and pinched her while she was still in the bathroom. The same note also stated R2 reported that R3 "goes in her room at night and pinches her bottom. No witnesses have stated anything to support that claim, but res.(male) doesn't deny walking in on her in the bathroom. He stated he touches her, but not inappropriately. Res. has history of making inappropriate sexual comments to staff and res. This has been care planned." R3's care plan, dated 01/10/05, for inappropriate sexual behavior states that this behavior is manifested by "Making crude, sexually-oriented, profane or suggestive remarks." The care plan also has a review date of 02/25/05 with no revisions or updates since the incidents that were documented on 02/09/05 and 02/10/05. No specific interventions were initiated regarding R3 going into R2's room and bathroom and touching her inappropriately. On 02/17/05 staff documented that R3 was harassing a young female staff member. When redirected by staff he became loud and verbal. On 02/27/05 staff documented that R3 was observed in hallway teasing another resident and	F9999		

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F9999	Continued From page 16	F9999		

bothering the nurse. The nurse¿s note does not give specific information as to what R3 actually said, but there were numerous notes stating that R3's comments are sexual in nature and inappropriate. When R3 was redirected for harassing the female staff member he told staff to mind their own business and "step outside, I'll beat your a**." R3 was sent to the hospital to be evaluated and returned the next day, 02/28/05 with a diagnosis of impulse control issues due to organic brain syndrome.

On 03/23/05 E1's note reflected the allegation about R3 going into R2's room. When asked by surveyor if he (E1) reported the allegation. E1 stated that everyone knew about it because he brought it up at the morning meeting. Surveyor interviewed E3 who was at the morning meeting of 03/23/05 and E3 stated that it didn't sound that serious to her.

Surveyor reviewed the incident reports for the month of March and found no record of any of the incidents being documented and reported, nor was there a record of the police being notified of the incident of 03/23/05.

Surveyor, accompanied by E6, re-interviewed R6 ; R6 repeated what she had witnessed in her room on 03/23/05. E6 told surveyor that she did not realize the seriousness of the situation until that moment. E6 met with the family of R3 who were in the facility during the investigation and discharged R3 from the facility. R3 left with family members at that time.