

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

PRINTED: 01/05/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>GENESIS HOUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>350 SYCAMORE ROAD</b> <b>GENOA, IL 60135</b>		
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W9999	<p>Continued From page 11 LICENSURE VIOLATIONS</p> <p>350.620a) 350.1060a)b)c)d)e)h) 350.1230b)3) 350.1230d)1)2)e)f) 350.3240a)f)</p> <p>Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.</p> <p>b) Each resident shall have individual evaluations which shall: 1) Be based upon the use of empirically reliable and valid instruments whenever such tools are available. 2) Provide the basis for prescribing an appropriate program of training experiences for the resident.</p> <p>c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that</p>	W9999			

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W9999	<p>Continued From page 12</p> <p>permit the progress of the individual to be assessed.</p> <p>d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.</p> <p>e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.</p> <p>h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.</p> <p>Section 350.1230 Nursing Services</p> <p>b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming.</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs</p>	W9999			

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W9999	<p>Continued From page 13 and problems of the residents.</p> <p>e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities.</p> <p>f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>f) 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. (Section 3-612 of the Act)</p> <p>Based on record review and interviews the facility failed to develop and implement procedures to prohibit mistreatment, neglect or abuse of R1 and R2 when they were victims of sexual abuse by a peer, R3.</p> <p>Findings include:</p> <p>Upon review of an Investigation Report dated 6-1-06, it states that "At approximately 5:10 p.m. in</p>	W9999			

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W9999	<p>Continued From page 14</p> <p>the bathroom of, (R3, a 52 year old mildly mentally retarded man, who was found), laying on top of female resident, (R2, a 43 year old profoundly mentally retarded woman). (R2) was laying face down crying and yelling trying to get up." R3 had his "penis in his hand trying to insert it into, (R2's), vagina. Neither resident had pants or underwear on at this time."</p> <p>Upon review of an Investigation Report dated 6-5-06, it states that "At approximately 2:10 a.m. male client, (R3) was found to be in the room of female client, (R1, a 49 year old profoundly mentally retarded woman). (R3) was found naked in (R1's) bed on top of (R1) who was also naked. (R3) was engaged in sexual intercourse with (R1). Staff observed penetration of (R3's) penis into the vagina of (R1).</p> <p>Per review of the facility's Behavioral Summary for R3 dated 6-6-06, it states that R3 does have " an ongoing history of sexual behaviors...most of these behaviors...have been done in private, in his bedroom involving only (R3), and some outward object-like a television, a magazine with a picture of a woman on it, a video case with a woman's picture on it, or a stuffed female bunny."</p> <p>R3's Behavioral Summary also notes that he is to be monitored closely due to his excessive liquid drinking. Since June 2005 R3's Inappropriate Sexual Behaviors, (ISB), are no longer just involving R3 and an outward object. In a variety of his ISB incidents, "he has been using other female clients to enhance his masturbatory adventures."</p> <p>*In June 2005--4 of the 12 incidents involved a female client 3 of these involved touching the</p>	W9999			

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W9999	<p>Continued From page 15 other client.</p> <p>*In July 2005--2 of the 3 incidents involved touching a female client.</p> <p>*In August 2005--4 of the 4 incidents involved looking at a female client/staff and masturbating.</p> <p>*In September 2005--5 of the 8 incidents involved looking at a female client/staff and masturbating and 1 of these incidents involved R3 running after the person he was looking at while masturbating calling out to them "Honey." One took place during a fire drill with a female resident where he lifted her dress and masturbated his penis towards her vaginal area.</p> <p>*In October 2005--9 of 9 incidents involved looking at a female resident/staff and masturbating. One took place during a fire drill with a female resident, who R3 was sitting behind and masturbating towards. Another involved R3 being naked masturbating his penis towards the female resident he was lying on top of who was clothed with her legs spread out.</p> <p>*In November 2005--one incident involved looking at a female resident and watching television while masturbating.</p> <p>*In December 2005--2 of 3 incidents involved looking at a female resident and masturbating.</p> <p>*In January 2006--2 of 3 incidents involved looking at a female resident and masturbating. One included making kissing noises towards the female resident and running over to her and touching her hair and blowing on her neck. All previous incidents were noted to have taken</p>	W9999			

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W9999	<p>Continued From page 16</p> <p>place in public/shared areas of the facility, this month one took place in the community at the library while R3 was looking at a book and masturbating.</p> <p>*In February 2006--3 of 3 incidents involved looking at a female resident and masturbating. One incident involved R3 running up to a female resident wheelchair user and kissing her on the face.</p> <p>*In March 2006--7 of 11 incidents involved looking at a female resident/staff and masturbating. One incident involved R3 running into the bathroom where he knew a female resident was and R3 trying to pull his pants down while she was on the toilet. Another involved running after a staff member and saying "jack off, " and then telling the staff to "let him touch the lady." 2 included intentionally moving his chair physically to be close to the female resident he wanted to masturbate with.</p> <p>*In April 2006--one incident involved looking at a female resident and masturbating.</p> <p>*In May 2006--1 of 2 incidents involved a female resident. R3 went to the activity room bathroom where a female resident was using the bathroom and he began masturbating in front of the female resident.</p> <p>*On June 1, 2006 R3 was found in his bathroom on top of R2 trying to insert his penis into her vagina, R2 was yelling and crying.</p> <p>*On June 5, 2006 R3 was found in R1's bedroom, they were both naked and R3 was on top of R1 and he was having sexual intercourse</p>	W9999			

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W9999	Continued From page 17 with her.  On 7-20-06 Executive Director E1 confirmed R3's behaviors, that he had attacked R2 attempting sexual intercourse, and that he did have sexual intercourse with R1. E1 acknowledged R3's history of ISB's. E1 discussed the facility's follow up actions to address R3's behaviors, including increasing R3's staff supervision level to being in the presence of staff, that they can visually see him. E1 also reviewed staff retraining and staff disciplinary actions, including the suspension of a nurse who was found to be the person who was supposed to monitor the hallways which could have prevented R3 from getting to R1's bedroom on 6-5-06. E1 said she understood that the facility's actions were insufficient to protect R1 and R2 from being sexually attacked by R3.  (A)	W9999			