| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14E847 | A. BUILDING _____ B. WING _____ | C 07/06/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRINGFIELD TERRACE | 525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703 |

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| F 324 | Continued From page 10<br><br>The Immediate Jeopardy situation was identified on 6/29/06. The Immediate jeopardy was determined to have begun on 6/27/06 when R1 sexually abused R3, after facility staff was aware that R1 had sexually abused R2. E1 was notified of the Immediate Jeopardy on 6/29/06 at 11:20 AM.<br><br>Through interview and record review the facility took the following steps to remove the immediacy :<br><br>1. R1 was removed from the facility by the local police department at 9:30PM on 6/27/06.<br>2. On 6/29/06 all staff was in-serviced verbally while on duty, or contacted by telephone. This training covered abuse prevention, dealing with abuse as it occurs and dealing with sexual abuse . All staff will be re-inserviced on 6/30/06 on the same topics.<br>3. On 6/29/06, the abuse policies were reviewed and updated as needed.<br>4. On 6/29/06 the Social Service Director will begin to provide any needed counseling to R2 and R3, for the next 7 days. | F 324 | | |
| F9999 | FINAL OBSERVATIONS<br><br>Licensure Violations<br><br>300.1210a)<br>300.1210b)6)<br>300.3240a)<br>300.3240f)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care | F9999 | | |

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| F9999 | Continued From page 11<br>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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.<br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br>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.<br><br>These requirements were not met as evidenced by the following:<br><br>Based on record review and interviews, the | F9999 | | |

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| F9999 | Continued From page 12<br>facility failed to implement preventive measures to protect 1 (R3) of 8 female residents on B Hall from sexual abuse after facility staff witnessed R1 on top of another female resident (R2) in her bed with his genitals exposed. The facility failed to immediately implement facility abuse policies and procedures assuring resident safety for R2's rommate, R3, after the resident to resident sexual abuse against R2 The facility failed to maintain constant visual surveillance of R1. This failure allowed R1 to re-enter the room and he was found on top of R3 in her bed with his genitals exposed.<br><br>Findings include:<br><br>R1 was previously discharged on 5/6/06 to a state hospital because of increased aggression towards staff and refusal to take medication. Record review indicates that on 6/27/06 at 11:30 am R1, a 46 year old resident with history of schizophrenia, was readmitted back to facility.<br><br>The following events were reported during interviews with E3 (LPN), E4 (CNA), and E5 ( CNA) on 6/28/06 at 4:00pm.<br><br>At 8:45pm on 6/27/06, E3 heard R2 screaming. E3 entered R2's room and found E1 attempting to hold R2 down on bed. R1 had his pants down with genitalia exposed. R2's gown was pulled up exposing her genitalia. R2 was screaming for staff to help. R1 was immediately pulled off of R2 by E3. R1 immediately ran to his room and slammed his door, directly across the hall from R 2 & R3's room.<br><br>E3 immediately went to the office to notify the Administrator and contact the police. E4 | F9999 | | |

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| F9999 | Continued From page 13<br>attended to R2, taking her to the dining/activity room. E5 stated that she then attempted to remove R3 (R2's roommate) from the room but R 3 refused. E5 stated she left to inform E3 of R3's refusal to leave the room. Then E5 attempted to remove other female residents from the B Hall corridor. During this time, E5 admitted she lost visual contact with R1. E5 returned a few minutes later and found R1 on top of R3, holding her down, on the bed. E5 reported that R 1's genitalia was exposed. R3 was not screaming at this time. R3's underwear was intact. E5 immediately grabbed R1. R1 left the room and was moving around to different areas of the facility. E5 stayed with R1 from a distance until police arrived on the scene at approximately 9:30pm and took R1 into custody and removed him from the facility.<br><br>Both R2 & R3 were later transferred to a hospital on 6/27/06 and initial assessments were conducted. Both residents refused pelvic examination.<br><br>On 6/28/06 and 6/29/06, R2 & R3 were interviewed. Both R2 & R3 denied that any sexual penetration had occurred during the incidents on 6/27/06. R2 commented that R1 had never previously acted like this before until this event.<br><br>On 6/29/06 R5 and R6, interviewable female residents on B Hall, were interviewed. They stated that they have not been sexually abused by R1 or any other resident in the facility.<br><br>Review of Facility Abuse Prevention Policy states under Subpart V, " Protection of Residents", " Residents who allegedly mistreated another | F9999 | | |

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| F9999 | Continued From page 14<br>resident will be removed from contact from that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable, care approaches and placement, considering his or her safety, as well of other residents and the employees of the facility."<br><br>(A) | F9999 | | |