STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING ______ B. WING ______	C 12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEROY MANOR	509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752

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F 490	Continued From page 47 11/28/07 - Clinical staff have reviewed the charts of all residents to determine if there are any residents exhibiting inappropriate behaviors that are not adequately addressed by their care plans. Care plans will be updated as appropriate. 11/30/07 - E8, E17 and E21 were suspended pending outcome of investigations. 11/30/07 - E34, Corporate Nursing Consultant, re-inserviced all administrative staff including the Administrator on the abuse policy. Areas of emphasis included the responsibility to investigate and report all allegations of abuse and the responsibility to suspended all alleged perpetrators regardless of when the allegation is received. 11/30/07 - E2, DON and E14, Administrative Assistant re-inserviced all staff on the abuse policy. No staff will be allowed to work prior to receiving this training. 12/1/07 - E2 replaced E1 as the Abuse Prohibition Coordinator. E1 began a leave of absence.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.510e) 300.610a) 300.690a) 300.695b) 300.1210a) 300.1210b)4) 300.3240a)	F9999		

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F9999	Continued From page 48 Section 300.510 Administrator e) The licensee and administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 300.610 Resident Care Policies a) The facility's policies shall be followed in the operation of the facility. Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have a significant effect on the health, safety of welfare of a resident or residents. Section 300.695 Contacting Local Law Enforcement b) the facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident or a visitor. Section 300.1210 General Requirements for Nursing ans Personal Care a)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. b)4) Personal care shall be provided on a 24-hour, seven day a week basis. Section 300.3240 Abuse and Neglect a) AN OWNER, LICENSEE, ADMINISTRATOR,	F9999		

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EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE A RESIDENT. (Section 2-107 of the Act)

These regulations are not met, as evidenced by the following:

Based on observation, record review and interview, the facility failed to investigate allegations of sexual and physical abuse and involuntary seclusion, failed to report the allegations to the Department of Public Health and other officials as required by State law, and failed to protect residents by allowing staff to continue working after becoming aware of abuse allegations. The facility failed to follow their policy for Abuse and Neglect by failing to implement protocols for Preventing, Reporting, Investigating, and Protecting to prevent additional allegations of inappropriate sexual behavior and allegations of abuse for 4 of 14 sampled residents. (R3, R5, R9, and R14). The facility failed to notify R3's Power of Attorney and family of inappropriate sexual intercourse.

The findings include:

1. On 11/07/07 at 2:50 p.m. during an interview with both E1, Administrator, and E2, Director of Nursing (DON), E2 stated that she was aware that R4 made "inappropriate comments asking ladies to go back to (R4's) room, of (R4) trying to get ladies to come into his room from the doorway to (R4's) room." E2 stated, "We are working with meds, (R4)was started on Lupron injections by the Urologist and was started on Seroquel and Ativan. E2 stated (R3) was found in (R4's) room, and they were together when E2 stated staff tried to redirect her. When asked if

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F9999	Continued From page 50 E2 was aware of any instance of inappropriate sexual behavior, E2 stated "more than one." (R4) has inappropriate situations if a female resident is found in his room. They can be at various points of undress. Each may have part of their clothing off. (R3) (These) residents, one or the other thought they were a spouse to the other. There was too strong of a connection...." During this interview E1, Administrator, stated, "If a Dementia person is assaulted - no one has been assaulted or hurt. No one has been sexually assaulted by (R4). There has been no resident complaint of inappropriate sexual behavior toward them..... The disease process removes inhibitions - a woman who may have said 'No' now without inhibitions may not say 'No' due to Dementia." During interview with E16, Certified Nurse Aide (CNA) on 11/14/07 at approximately 3:00 p.m., E16 recalled that in "June or July, (E16) went to put (R3) to bed and found (R3) in bed with (R4), spooning. (R3) was naked from the waist down. They (R3 and R4) were cuddling. I took (R3) to her room." The next night, E16 worked with a new CNA, E23. E16 stated that it was E23's first night as a CNA. E16 stated (R3) was usually one of the first to go to bed. I was looking for (R3) to get her ready for bed at about 6:00 p.m. to 6:30 p.m. I walked into (R4's) room with (E23). They (R3 and R4) were having sex. (R4) sat up and got up off the bed. (R4) still had an erection. I told (E8, Registered Nurse, RN) and (E29, Licensed Practical Nurse, LPN) what I saw and they immediately came to the room. All of us returned (R3) to her room. (E8) wanted to do a vaginal exam. (E8) stated, (R3) was definitely wet and (E8) thought that (R3) had definitely had sex. (E8) asked (R3) 'What were you doing?'	F9999		

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F9999	Continued From page 51 (and) (R3) said, 'You know.'" "(R3) was not happy that she was interrupted. At that point, I didn't know what to think. But, (R3) is very dependent upon us for care. (R3) doesn't know time, night from day. Sometimes (R3) does not know where her room is, or how to take care of herself." During interview on 11/14/07 at 12:15 p.m. with E14, Administrative Assistant, E14 stated that sometime around "mid-July," she received a phone call from E1, Administrator, informing her of an "incident." E14 stated that she called (E8, RN), and talked with her on the phone regarding what had happened. E14, Administrative Assistance, stated that E1 directed her to come to the facility to talk with (E16, CNA). According to E14, E16 said "Yes I did," when asked if she saw penetration. E14 told E1 what was said. (E1) said she had contacted Corporate and was told "that if two demented residents are consenting - it is a normal behavior. It is a normal behavior to have sex." Later in the interview, E14 stated "I just talked to (E16) and (E8) because they were the only two that I was aware of that were involved. I never talked to any other staff about the incident."......" I did not interview either resident and had talked to (E8) on the phone only." During interview with E8, RN, on 11/26/07 at 10:30 a.m., E8 stated that "Staff (E16 and E23, CNA's) called her to (R4's) room. I went to the room. (R4) was by the door, naked with an erection. Staff were assisting (R3), who was naked, to get up out of bed. I covered (R3) with a sheet and took her to her room. I did a digital exam to check for trauma. There was no bruising, redness or swelling." "I called (E2,	F9999		

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DON) immediately and was directed to call (E1), Administrator and Abuse Coordinator. I called (E1). (E1) called back and asked questions, "Was there mental capacity?" (E1) told me to call the Police and then said 'Let me talk to Corporate first.' (E1) called back and said 'they (R3, R4) were both consenting adults,' and she would have to call the families and (Power of Attorneys, POA's) to make sure that it was all right with them and then (R3 and R4) could continue. (E1) stated, 'for right now, separate them.' "

According to E8, RN, "(E1) told me on the phone to be vague and not chart specifics and not to say anything about the penetration because I did not witness it." "(E16, CNA) said (E14, Administrative Assistant) tried to say that there was no way she (E16) could have seen penetration. (E16) was crying and said 'I just don't feel right about this and it's going to come back to bite us in the butt." E8 said "I was not interviewed as part of an investigation."

During interview with E23, CNA on 11/15/07 at 4:00 p.m., she stated that on 7/18/07, she worked the 3:00 p.m. to 11:00 p.m. shift. E23 stated that she was asked to give a resident a shower and went to find her (R3). "(R3) was in (R4's) room. (R4) was on top of (R3) and had nothing on. They were having intercourse." E23 said, "I was asked if I was going to tell by (E16 and E8). And everybody said 'just put it under the table.'" "(R4) and (R3) were separated,and (E8,RN) physically checked (R3). (R4) appeared as if he knew he was doing something wrong." E23 stated, no facility staff called her to get her witness statement to this incident.

During interview on 11/14/07 at 9:10 a.m., E1,

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F9999	Continued From page 53 Administrator, stated "there was an incident of consensual sex that I investigated." E1 stated, "(E8, Registered Nurse (RN) called me and said a CNA witnessed (R4 and R3) in the act of intercourse." During same interview, E1 said, "(E8) or the nurse should have reported this incident to families and physician per facility policy." "I do not know for a fact" that this was done. "I have a concern that the CNA could actually see his penis in her vagina. (E14) and I interviewed (E16) together and (E14) interviewed (E16) in person that night." E1 further stated, "Sexual activities is a normal activity." "If they both were enjoying that activity, who's to say it is wrong." "When someone doesn't want something they fight. When a person has dementia they fight even more." E1 was asked to present assessments documenting R4's and R3's ability to make consensual decisions to have sex. No assessments were available. E1 provided four typed summary style documents relating to the 7/18/07 incident (dated 7/19, 7/19, one undated and 11/12/07). None of the documents were signed. They did not include documented interviews of the 2 witnesses or the 2 residents involved. Review of a type written report dated 7/18/07 showed that E14, Administrative Assistant, came to the facility on the evening of 7/18/07 and interviewed E16, CNA. According to the report, E14 asked E16 what happened and what E16 had seen. E16 stated that E16 and E23 walked into (R4's) room and found (R4) lying on top of (R3) naked. E14 asked E16 where were you at in the room? She said I was at the foot of the bed and when I came in the room (R4) saw us	F9999		

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F9999	Continued From page 54 and he jumped up. E14 asked E16 if there was penetration and she said yes. (E14) said are you sure? And E16 said yes, I know what I saw. During an interview with E2, DON, on 11/14/07 at 10:00 a.m., when asked, "Do they (R3, R4) have the ability to make a consensual decision," E2 answered, "Probably Not." E2, was asked if staff had completed an assessment to document (R4 and R3's) ability to make knowledgeable sexual consent decisions. E2 stated "no such assessments had been completed." E2 stated, "The call was (E1's). She contacted E14, Administrative Assistant, who interviewed staff." Z2 (R3's POA) was interviewed at 1:55 p.m. on 11/14/07. When asked if (R3) would be capable of making a choice regarding sexual intimacy he replied, "No. (R3) is not able to make any choices. She knows who we are, but that is all." "If something happened she would not be able to recall it." Z2 acknowledged he was aware that R3 had been moved off the 300/400 Wing in July, but stated he was not told the reason for the move and had not been informed of any alleged sexual activity involving R3. Z3, (R3's family) was interviewed on 11/14/07 at 3:35 p.m. When asked if (R3) had the mental capacity to make a decision regarding sexual relations, Z3 answered, "No." When asked, "Prior to your mother having her current dementia, would you feel she would consent to such a sexual relation," Z3 replied, "Oh no." "She cannot make decisions or would not be able to make sense of what you are asking her." When asked about R3's room change in July, Z3 said that it was because, "she was disrobing in the wrong room. It was a man's room." Z3 was not	F9999		

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aware of the alleged sexual activity involving R3. Interview with E28, Social Services, on 11/14/07 at 2:55 p.m. showed that she called family about the room move but did not give a reason.

In the facility Abuse Policy, Section B lists the "Initial steps and reports of alleged abuse or neglect."
Number 1 requires "Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator ."
Section 2 states "If the incident involves alleged abuse or neglect, the Administrator shall provide the Illinois Department of Public Health with initial notice of the alleged abuse or neglect......within 24 hours."
Section B) 3) reads "3. The administration shall immediately contact local law enforcement authorities in the following situations: - Sexual abuse of a resident by a staff member, another resident or a visitor:"

2. During interview on 11/15/07 at 4:00 p.m. with E23 (CNA), who witnessed the sexual activity between R3 and R4 on 7/18/07, E23 made additional allegations of resident abuse.
In addition to the allegation of sexual abuse on 7/18/07, E23 stated that on 7/19/07 on the 3-11 shift, "when we went to get (R9) ready for supper, he had a (bowel movement (BM)." (R9) was hitting and "staff forcibly threw him on the floor and he fell." "Staff were verbally abusive towards him." "(E31, CNA) and (E16, CNA)...When we got the residents ready for dinner, they locked the residents in the dining room. No staff were in the dining room. (E31, CNA), was holding the door so residents could not get out of dining room. (E26, CNA Coordinator) was there and knew of

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this." When asked why (E23) didn't report the other incidents, she said "they didn't do anything about (R4 and R3) - why would they about the other incidents. I needed to quit because of morals."

E1, Administrator, was informed of the new allegations on 11/15/07 at the Daily Status Meeting at approximately 4:50 p.m. On 11/26/07 at 10:50 a.m., E1 was asked if she was still the Abuse Coordinator. E1 stated that she was. When asked what had been done as far as an investigation into the allegations made by E23, CNA, which were given to the facility at the daily status meeting on 11/15/07, E1 stated, "(E23) no longer worked at the facility and the allegation occurred long ago. I have not done anything in regards to investigating these allegations since informed on 11/15/07." E1, also confirmed that the allegations had not been reported to the Department, and the alleged perpetrators were still working. It was at this time that E1 left and returned with written interviews dated July 2007 from E26, CNA, E31, CNA and E9 CNA regarding the allegations of physical and verbal abuse on 7/19/07.

On 11/26/07 at 2:45 p.m., E16, CNA was observed standing at the nurse's station on the 300/400 Hallway. E16 stated she was scheduled to work from 2:00 p.m. until 10:30 p.m. tonight.

On 11/26/07 at 3:30 p.m., E1, Administrator, was asked to explain why (E16, CNA), was still working when (E16) was alleged to be involved in the abuse of (R9). E1 stated, "(E16) is a nursing student and (E23) only worked here a day and a half." When questioned about the allegations of physical abuse and seclusion, E1 stated she had

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not re-opened the R9 allegation or the seclusion of 7/19/07, as she had been told she was intimidating staff and did not want to interfere.

3. On 11/29/07 at 9:50 a.m., E15, CNA, related an incident which occurred in the small dining room at lunch time on 11/27/07. E17, CNA, "was standing behind (R5's) chair holding it against the dining room table. (R5) was trying to stand up. (R5) was hitting the table, kicking and trying to get the chair back. (E17) continued to hold the chair in place." E15 stated E30, Activity Aide, "stuck her finger in (R5's) face and told (R5) to sit down or she (E30) was throwing her (R5) food in the garbage....(R5) continued to kick and hit the table." Then E15 pulled the chair out a little bit, so R5 could stand, and E8, RN, entered the dining room and said, "Hold her there because I have a shot of Ativan." E15 stated E17 and E30 physically held R5 while R5 was standing, and E8 pulled R5's pants down and gave the injection in R5's hip. E8 and E17 then left the dining room, and E30 (Activity Aide) stopped in the doorway of the dining room and placed her hands on both sides of the door with her arms outreached. "(R5) was pushing on E30's back, in an effort to exit the dining room." E15 stated she then went to E2, DON, and reported all the above facts, and E30 was called to E2's office.

Included in the facility's investigation were documented interviews with E30 (Activity Assistant), E31, Room Assistant, and E15, E17 and E19 (CNAs), all dated 11/27/07. These interviews supported that E30 was verbally abusive to R5 and blocked R5 from leaving the room, that E17 held R5's chair against the table so R5 could not remove herself from the table, and that E17 and another CNA held R5 while E8

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F9999	Continued From page 58 administered an injection to R5 in the dining room. E17's signed interview documents, "I tried to sit (R5) down for lunch: she tried to bite me, pinch me and slap me in the head. She called me a "--- - - -----" approximately 5 times. She had repetitive pinching, slapping, biting and cussing - it lasted about 20 minutes...... I stood behind her chair, I had her fork with food on it and tried to get her to take a few bites of food. (R5) pushed the table forward....(E8) came in and gave her a shot. I let her go and told her if she didn't want to eat she didn't have to." E8, RN was interviewed on 11/29/07 at 11:20 a.m. regarding the incident with R5 on 11/27/07. E8 confirmed she gave R5 an injection of Ativan, stating E17 and another CNA held R5 while E8 administered the injection. E8 continued, "It usually takes 3 of us but she (R5) was extra fighting that day. Usually it takes one on each side." On 11/29/07 at 12:30 p.m., E2, DON, confirmed E15 had reported the above incident to her on 11/27/07, and E2 had reported the incident to E1, Abuse Coordinator and Administrator, and to E14, Administrative Assistant on 11/27/07. E2 stated she and E14 had initiated an investigation, E30 admitted to verbal abuse towards R5 and was terminated on 11/27/07 for this verbal abuse. E2 stated facility staff had not reported the allegation of abuse involving R5 to the Department of Public Health until 11/29/07. The report submitted indicated the investigation was in progress, and only addressed the verbal abuse by E30 to R5. The Employee schedule indicated E17 was scheduled on the 300/400 unit on 11/27, 28 and 29/07. E8 and E17 were providing direct resident care on 11/29/07 on the 300/400 Wing.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING ______ B. WING ______	C 12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEROY MANOR	509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752

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F9999	Continued From page 59 4. E2 (Director of Nurses), E7 (CNA) and E15 (CNA) were interviewed on 11/29/07 at 12:30 p.m., 9:15 a.m. and 9:50 a.m. respectively. E15 stated that on 11/26/07 at either breakfast or lunch (unsure which) E15 was unable to open the door to enter the small dining room on the 400 Hall. E15 stated the door to the room opens into the room, but the nurse's medication cart was just inside the dining room obstructing the door. The wheels on the medication cart were locked, preventing E15 from moving the cart. E8, Registered Nurse (RN) and E21 (CNA) were seated at the first table inside the room. E15 stated, "probably 13 residents were in the room." E15 stated, "I finally opened the door a little bit, to kick (release) the brakes so I could move the cart out of the way. I put the cart in front of the sink. I got a clothing protector and left the room. As I left the room E21 placed the med cart back against the door." E15 stated E8, RN, saw E15 enter, and saw E21 reposition the medication cart to obstruct the door. E15 stated she then went straight to E2's office and reported the incident. E2 stated she would, "fix this problem" and went to the dining room. E7, CNA, stated at breakfast on 11/26/07, "(E8, RN) had the med cart in front of the door so the residents could not get out. We had to move the med cart each time we brought residents into the small dining room....(E8) had the brakes locked on the med cart.....What they was trying to do was keep (R14) and (R5) in there..... (R5) and (R14) were trying to get out through the door, mostly (R5), and were not able due to the med cart." E7 stated approximately 10 residents were in the dining room, the med cart was located right inside the room, and E8 was in the room feeding	F9999		

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F9999	Continued From page 60 a resident. E7 estimated the door was blocked by the med cart for approximately 15 to 20 minutes that she was aware of, and that E2 (DON) came and told staff they could not block the doorway. E7 stated, "This has been a common practice. A lot of the CNA's do it at night too. They just lock the door (to the small dining room) and sit in a chair inside to block the door." E2, DON, stated that shortly after 7:00 a.m. on 11/26/07 E15, CNA, reported to her that the door to the dining room was shut and the medication cart was blocking it. E2 immediately went to the area and saw the door shut and the med cart in front of the door in the dining room. "It was obstructing people's ability to get out." E2 stated E8 (RN), and E7 and E27 (CNA's) were in the dining room with approximately 10 residents. When asked why the staff had blocked the door with the medication cart, E2 stated, "They had had to get (R5) about 10 times - so they were trying to get her to stay in the dining room and eat." E2 stated she directed E8 to moved the med cart, and informed staff if it happened again it would result in disciplinary action. E2 stated she provided staff inservices on "seclusion and the dining room practice" on 11/27 and 11/28/07. When asked for the written statements from involved staff regarding the incident of seclusion on 11/26/07, E2 stated she did not obtain statements from staff since she witnessed it herself. E2 then asked, "For my general knowledge, what is the definition of seclusion? I didn't report this incident to anyone because I didn't view it as seclusion." E2 stated she did not informed E1, Administrator and Abuse Coordinator, of the incident of seclusion on 11/26/07 until 11/29/07.	F9999		

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F9999	Continued From page 61 E8, RN, was working on the 300/400 Wing on 11/29/07, and was interviewed at 11:20 a.m. E8 denied having the medication cart in front of the dining room door to block passage on 11/26/07, stating, "No, I was passing my meds." E8 confirmed E2 directed her to move the med cart and told her she could not have the cart in front of the door. E8 stated that until the inservice on 11/27 she, "didn't know what seclusion was." E8 stated she was not removed from direct resident contact at any time on 11/26/07. E8 stated she worked the day shift on 11/27/07 and was working a full shift on 11/29/07. (A)	F9999		