STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A151	A. BUILDING _____ B. WING _____	03/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOURBONNAIS TERRACE	133 MOHAWK DRIVE BOURBONNAIS, IL 60914

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 501	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on interviews and record review facilities medical director is not involved with identifying, analyzing, addressing/resolving clinical concerns related to allegations of abuse, aggressive/harmful behaviors in the facility. Findings include: During 3/13/09 telephone interview of Z1 (Medical Director), he is not involved in QA's related to abuse or behavior problems in facility, he only deals with medical issues, not psychological issues or situations involving the police. During interview with E1, E2 and E4, surveyor was notified that facility is only working on inappropriate smoking in facilities quality assurance committee.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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	F9999		

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F9999	Continued From page 54 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. b)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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to: - prevent R33 from being sexually abused on 01/17/09 by R31 on 01/17/09, approximately 10 hours after re-admission from hospital evaluation for being sexually inappropriate with a another female resident. R31 physically pushed R33 up against her television, knocked her down onto a crate, grabbed ahold of her genitalia and would not release until R33 sprayed him in the face with aerosol antiperspirant. R31 had an identified offender status for violent aggressive behaviors (Murder conviction in 1990), which was not provided to facility from transferring sister facility on 01/07/09. Facility failed to assess and monitor R31 timely and appropriately to prevent this abuse. - prevent staff from being abrupt, rough, rude, demoralizing and controlling to multiple residents	F9999		

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F9999	Continued From page 55 by laughing at residents while gossiping about residents amongst each other in front of residents, and threatening to write them up which affects the residents' "Level" and privilege ability. This resulted in residents feeling demoralized and afraid to voice complaints due to fear of retaliation from staff. This applies to 25 of 195 current residents and one discharged resident with aggressive behaviors, (R31). Findings include: During facility abuse protocol and incident report review surveyor found the following investigations; 1) On 01/17/09 at 9:45AM R31 entered R33's room and touched her in a sexually inappropriate place and pushed her onto the bed. R33 was heard screaming by staff. The report included a written statement by R33 that included that R31 entered her room uninvited at 5:20AM, while she was only wearing a bra. R31 has done this 3 times now. R31 asked R33 if he could buy her television for $1.00 and when R33 said no he left the room and sat outside R33's room, waiting for her. At 9:45AM R31 walked into R33's room and R33 told him to leave but R31 backed R33 against a television, R33 hit him and then R33 fell down onto a crate. R31 then grabbed R33's crotch and would not let go! R33 tried to reach the emergency call light but R31 would not let her. R33 was able to reach into her drawer and pull out a can of aerosol deodorant and spray it into R31's face. This gave R33 a chance to run to the door and yell for help. R33 wrote that she thought R31 was going to hurt her, he would not	F9999		

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F9999	Continued From page 56 get off her and that she fears he will come back and kill her. The investigation included a written statement by E33 (CNA), stating that she observed R31 sitting outside R33's room on the morning of 01/17/09, prior to the 9:45AM incident. R31 was a transfer admit from a sister facility on 01/7/09 with diagnosis to include Chronic Schizophrenia. A 01/09/09 interim care plan included that R31 has hallucinations, delusions, a history of substance abuse, and was receiving psychotropic medications. R31's 01/08/09 nurses notes include a behavior of wandering into other resident rooms. R31's 01/16/09 psych evaluation includes paranoia, hostility, loose association and hostile behaviors. R31's 01/16/09 8:30PM nurses note includes going into other residents' rooms, staff unable to re-direct him. A female resident alleged that R31 entered her roomand un-zipped his pants in front of her. R31 was sent to hospital for evaluation at 9:48PM but was sent right back and re-admitted at 10:50PM. The next and last nurses note was the 01/17/09 incident of R31 sexually assaulting R33. R31's chart did not include an aggressive/harmful behavior risk assessment since admit, and did not include any social service or psycho social notes with these behaviors or a plan to prevent aggressive or sexually inappropriate behaviors. During interview E1 (Administrator) told	F9999		

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F9999	Continued From page 57 surveyors that R31's identified offender status was not included with his 01/07/09 admission transfer forms from a sister facility. R31 has a history of a Murder conviction in 1990. 2) During the survey multiple residents approached surveyors and voiced complaints about nursing and dietary staff being rude, handling residents roughly, disrespectful, abrupt, pushy, demanding, threatening, and laughing at and gossiping about residents in front of other residents and staff. If a resident is incontinent during a meal the staff tell them they have to stay wet until after the meal. Residents voiced fear of retaliation if they voice a complaint to administration. Two staff named were E6 and E15 (nurse aides). Incident reports included incidents of nursing staff treating residents inappropriately. - 02/04/09 R23 alleged that E6 was abrupt, pushy and argumentative with her and that E6 hit her in the hand. Facility investigation report concluded that E6 was inappropriately interacting with residents and received a write up. - 3/10/09 R7 alleged that E6 threatened to write up the resident if she did not leave the patio area. E6 said that she was locking it up but the facility policy is for residents to be able to go outside on patio and smoke with supervision until dark. R7's and E16's (nurse aides) written statements concur that E6 insisted the patio be closed and locked up before dark on 3/09/09. E6 was suspended for two days and eventually terminated 3/16/09 for inappropriate interactions and attitude toward residents. E16 also noted that E15 (nurse aide) was involved with demanding residents get off patio and inside	F9999		

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F9999	Continued From page 58 before the patio was supposed to be closed. - 3/10/09 R45 alleged that on 3/09/09 she heard someone call her a "fat a..." When she looked around to see who said it she saw E25 (nurse aide) laughing. R45 became upset and called E25 a "Bit..." E25 told R45 that she was going to write R45 up and R45 apologized. E25 refuse to accept the apology from R45. E25 was suspended 3/10/09 and terminated 3/16/09 for inappropriate response to resident behaviors. (A)	F9999		