STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146068	A. BUILDING _____ B. WING _____	C 04/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY ACRES NURSING HOME	19130 SUNNY ACRES ROAD PETERSBURG, IL 62675

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F9999	Continued From page 14 LICENSURE VIOLATIONS 300.695b)3) 300.695c)1) 300.3240a) 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. c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that 2 out of 8 sampled residents (R1, R2) were not subjected to repetitious sexual abuse by the same perpetrator (Z2). R1 was subjected to two witnessed sexual abuse incidents by a visitor (Z2). Staff members (E6, E9) reported the incident took place minutes	F9999		

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F9999	Continued From page 15 apart in a facility hallway. Z2 had been witnessed by E9 (CNA) sexually abusing another resident (R2) 2-4 weeks earlier. The initial incident was reported to E1 (Administrator) and E2 (D.O.N.- Director of Nursing). No interventions were established after the first incident to protect residents from Z2's advances. Day shift nursing staff were advised to let E1 know if Z2 entered the building. Findings include: 1. On 3/18/09 at 8:20 p.m. E9 ("Junior Certified Nurse Aide"- CNA) reported seeing Z2 walking down the hallway on 3/14/09 at about 7:00p.m. E9 followed Z2 because of a previous inappropriate incident E9 witnessed in February with another resident. Z2 kissed R1 on the mouth in the hallway. R1 yelled out at Z2. Z2 signed something to R1; however R1 continued to yell. Z2 then grabbed R1's left breast and started poking this area. A written account of the incident dated 3/14/09 by E9 was made available from E1. On 3/18/09 at 7:33 p.m. E6 (housekeeper) reported witnessing Z2 grabbing and touching R1's breast in her room on 3/14/09 at approx 7:00 p.m. E6 had transported another resident back from the dining room to an adjacent room. E6 then went running down the hall to tell the nurse (E5) what was seen. E5 and E6 started walking toward R1's room. Z2 came out of R1's room and passed them in the hallway and left the building. E6 states incident was reported to E4 (Licensed Practical Nurse- LPN) who reported activity to E2 (DON). E6 (CNA) said E2 reported incident with Z2 to E1 (Administrator). A written account of the incident dated 3/14/09 by E6 was	F9999		

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F9999	Continued From page 16 made available from E1. According to R1's Face Sheet and 3/27/09 Physician Orders Sheet R1 is an 88 yr old with diagnoses including Dementia, Arthritis of Spine, Legally Deaf, Depression and Cataracts. R1's Minimum Data Set (MDS) dated 2/18/09 reflects R1 has severely impaired decision making skills, rarely understands others, is dependent on staff for activities of daily living (ADL's), is incontinent, and can only communicate by signing, gestures and sounds. 2. On 3/18/09 during the same conversation as #1, E9 reported entering R2's room on day shift and seeing Z2 behind the curtain standing next to R2's bed, two to four weeks prior to the 3/14/09 incident. E9 stated that Z2 had his hand under the blanket down by R2's crouch area. E9 reported making a noise. Z2 quickly removed hand from under the blanket and left the room. E9 checked under R2's blanket to make sure there was no problem and found that R2 had on only a shirt - nothing else. E9 reported going directly to E2 (DON) and reported what was witnessed in R2's room. E9 was told by E2 a written report was not needed. "If you see him [Z2] again let me know. Go on with your day." E9 (CNA) said the police were not called. Z2 was allowed full access to facility and continued to visit with and without his wife. A written account of the incident dated 4/09/09 by E9 was made available from E1. According to R2's Face Sheet and Nurses Notes dated 3/9/09 R2 is a 79 year old with diagnoses that includes Dementia, Trans Cerebral Ischemia, Depression and Osteoporosis. R2 is confused to place and time, Activities of Daily Living (ADL)	F9999		

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F9999	Continued From page 17	F9999		

and personal hygiene are dependent on staff. R2 is fed by staff and requires two staff to transfer R2 to the wheelchair. MDS dated 12/19/08 reflects that R2 has severely impaired cognitive/decision making abilities, is unable to ambulate, and has limitations with range of motion (ROM) of head and neck.

An attempt to interview R2 at the bedside on 4/8/09 at 10:00 a.m. was unsuccessful.

According to E1 on 3/18/09 at 11:50 a.m., Z2 continued to have access to R2 while visiting the facility after E9 witnessed and reported inappropriate behavior Z2 displayed with R2. E1 told the DON that Z2 needed to talk to E1.

On 4/8/09 the determination was made, cognitively impaired, dependent residents (R1and R2) were put at risk for potential further abuse and harm by Z2's unrestricted access to them. These residents were identified to be at risk due to repetitious failure to promptly identify, report, and investigate allegations of abuse.

3. E2 (DON), interviewed on 4/6/09 at 10:05 a.m., reported that E1 said to make nursing staff aware that if Z2 was seen in the facility they were to let E1 know. E1 indicated that they would not complete an incident report until he could speak with Z2 and see why he had his hands under R2's blanket. According to E2, all the day shift nurses were made aware to notify administration if Z2 were to come into the building after the incident with R2. However, evening shift was not informed they needed to watch for Z2 and to notify administration if he came into the building. Per E2, since the incident had occurred on the day shift, that was why only day shift was

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F9999	Continued From page 18 informed. 4. Based on staff interviews (E2, E6, E9, E11) completed on 4/6/09 from 11:00 a.m.until 4:20 p.m., it was known Z2 came to visit various times of the day and evening. 5. Interviews with staff on 4/6/09 from 11:00 a.m. until 4:20 p.m.found that 5 out of 17 staff sampled (E12, E14, E17, E18, E19) stated they would not be able to identify and report Z2 to administration if he walked through the facility. 6. E1 (Administrator) has been unable to speak with Z2. E1 reported to surveyor on 4/8/09 at 1:45 p.m. in E1's office that E1 had tried once unsuccessfully to call Z2. E1 was not successful speaking to Z2 at the facility. Once Z2 had left the building before E1 was notified. The other time Z2 was observed at the facility, E1 was not on the premises. 7. Facility Abuse and Neglect Program Policy-Approved December 1999 was reviewed: Procedure- Investigations states: #3. ..."If the alleged perpetrator is not a partner, that person will be asked to leave the facility immediately. If a partner or other person refuses to leave the facility after being asked, the local police will be called to remove them from the property." Additional policy listed under Procedure-Reporting #1,#2. If any incidents or possible incidents of verbal, sexual, physical and mental abuse... the administrator will notify the following agencies within 24 hours of the incident: 1. Legal Guardian, 2. Physician, 3. Illinois Department of Public Health, 4. Illinois State Police....	F9999		

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F9999	Continued From page 19 Additional policy listed under Procedure-Protection/ Response #1. All residents will be protected from harm during the investigation of possible abuse. 8. Interview with E1 on 4/9/09 at 11:15 a.m. in E1's office, surveyor asked E1 when and how the police were notified. E1 stated not being sure of who or when the police were notified of the 3/14/09 alleged incident. E1 reported that the County police came to the facility early Sunday morning (3/15/09) and returned Sunday evening and picked up Z2. 9. Interview with Z3 on 3/17/09 by phone at 2:10 p.m. reported calling 911 and the County Police on 3/14/09 regarding an inappropriate incident at the facility that had not been reported. The incident had been reported to Z3, as a concerned citizen, and Z3 felt the need to report on to the police. 10. Interview with E2 (DON) on 4/9/09 at 11:15 a.m. in the Administrator's office, as well as documentation dated the same date in both charts, list R1 and R2's physician notifications of witnessed abuse as 3-17-09. R1's family was notified 3-19-09; R2's family was notified 3-17-09 by physician. (A)	F9999		