STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145614	A. BUILDING _____ B. WING _____	C 05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU NRSG & REHAB CENTER	**7050 MADISON STREET WILLOWBROOK, IL 60521**

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F 223	Continued From page 7 level two: a. inserviced staff regarding abuse and neglect; and red flags for potential abuse and neglect. b. all residents on that unit who were at risk for possible alleged assault behaviors were assessed. c. all residents have been re-evaluated for any history of sexually inappropriate behaviors While the immediacy was removed on 5/7/09 at 11:45 am the severity level remains at level two in order to allow sufficient time to evaluate the changes made in response to the Jeopardy situation and to monitor compliance.	F 223		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.3240a) 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 psychosocial 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. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	F9999		

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F9999	Continued From page 8 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 record review and interview, the facility failed to supervise a male resident (R1) who had a history of sexually inappropriate behavior and had approached two facility staff for sexual favors. This resulted in non-consensual sexual abuse of a a female resident (R2) by a male resident (R1). Findings include: 1. R1 was admitted to the facility on 5/6/09 at around 12:30 pm with diagnoses including Hypertension, Diabetes Mellitus, Schizo-Affective Disorder, Dementia, and Depression according to the facility's document titled "Recent Progress Notes." The facility's face sheet documents that R1 was 67 years old. A Consultation Report dated 5/1/09 from the Hospital documents that R1 was transferred to the hospital for psychiatric evaluation since R1 was somewhat agitated, irritable, and sexually acting out. A Psychiatric Evaluation dated 5/2/09 documents that R1 has been hospitalized several times in different psychiatric hospitals for treatment of dementia and depressive disorder. A History and Physical Examination dated 5/3/09 documents that R1 was aggressive at home, wandering out of the house and abusive to the neighbors. A Psychosocial Assessment dated 5/4/09 documents according to R1's clinical record and R1's family, R1 has been displaying bizarre behaviors including wandering off and	F9999		

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F9999	Continued From page 9 making sexual comments to female neighbors. A review of written statements and interviews denotes the following: a. On 5/7/09 at around 3:30 am E4, Certified Nursing Assistant (CNA - night shift) assisted R1 to the toilet. When R1 pulled his pants down he told E4 to give him some. When E4 did not understand what R1 was asking for, R1 then gestured sticking his finger into his other hand's fist. E4 then notified E5 (Nurse - night shift) and E6 (Nurse - day shift) regarding this behavior. b. On 5/7/09 at around 8:45 am R1 made advances to E7 (CNA - day shift). R1 stated that he needed a favor, and it was not helping him to get dressed. R1 requested E7 to have sex with him. R1 also described his penis to E7. E7 declined R1's advances, and as she was leaving his room, R1 grabbed her forearm and leaned to kiss her and stated "Get into bed, I love you." E7 immediately left R1's room and notified E6 regarding this behavior. E6 advised E7 not to go to R1's room alone. So E7 then had E8 (CNA - day shift) accompany her to R1's room. While accompanying R1 to the dining room R1 was telling E7 to meet him in his room. After eating breakfast R1 approached E7 and asked to come to his room. This was verified by E7 and E8 on 5/15/09 at around 1:52 pm and 1:25 pm respectively. E8 also confirmed that R1 was asking E7 to have sex with him. c. On 5/7/09 at around 10:20 am E9 (Nurse - day shift) observed R2 lying on R1's bed naked from waist down by. When E9 called for help R1 stated "Please do not tell anybody." E9 also observed small amount of discharge on R2's	F9999		

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F9999	Continued From page 10	F9999		

private area. This was confirmed by E9 on 5/22/09 at 3:50 pm.

During the interview with E6, E7 and E8 on 5/15/09 all stated that when E9 called for help they saw R2 lying across R1's bed. R2 had no pants, no diaper, no shoes. E6 stated that when found R2's legs were bent at her knees and her feet were at the edge of the bed and R2's specialized wheelchair was by the foot of the bed. E7 and E8 stated that they observed creamy white substance between R2's legs. E7 also stated that she observed the creamy white substance on the bedspread. E7 further stated that R2 looked "angry," was swinging her fist in air and saying "Son of a bitch."

E10 (Co-Social Service Director) was interviewed on 5/22/09 at around 12:29 pm. E10's written statement was also reviewed. Both interview and review of the written statement showed that at around 11:00 am E10 entered R2's room. R2 appeared very agitated, mumbling words that did not make sense. Then R2 began swearing saying repeatedly, "Son of a bitch" and pointing to outside the door. Then R2 became more agitated, pulling covers off of her, exposing herself. R2 was laying in bed with a gown on and a blanket over her. R2 did not have diaper on, but was laying on top of a pad. R2 seemed to want to get out of bed as she was trying to lift her head up and wanting to scoot off the bed. R2 was redirected to stay in bed. Then R2 repeatedly said "Son of a bitch" and placed her hands over her genital area above the sheets. Eventually, R2 calmed down and fell asleep until ambulance attendants woke her up and transported her to the local hospital. E10 also stated that R1 was not appropriate to be placed in the "Memory

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F9999	Continued From page 11 Loss" unit which houses residents with dementia. E10 further added that R1 was not appropriate to be placed in this facility. Z2 (Physician) was interviewed on 5/29/09 at around 11:55 am. Z2 stated that R2 was not capable of giving consent for sexual interaction. During the interview with E6, E7, E8 on 5/15/09, and with E9 on 5/22/09, all stated that R2 was not capable of giving consent for sexual interaction. All staff stated that R2 cannot stand up and needs staff assistance for transfer. E6 and E7 confirmed that other than E1 (Administrator) talking to R1 and the staff being advised not to go to R1's room alone there was no intervention done after R1 approached the staff for sexual favors. E3 (DON) was interviewed on 5/22/09 at around 10:22 am. E3 stated that after reviewing R1's history and physical from the hospital she was concerned about R1's sexual behavior and felt that R1 had psychiatric needs that they could not provide. E3 further stated that R1 was a wanderer, he was going to the neighbors and asking for sexual favors and the facility did not have psychiatric services like milieu therapy and psychotherapy that would facilitate R1's needs, so her final decision was not to admit R1 to the facility. E1 (Administrator) asked E3 to reconsider accepting R1, as residents with dementia frequently say these things but they do not follow through, so E3 accepted R1 for admission to the facility on 5/6/09. E3 further stated that on 5/7/09 at around 8:45 am E6 told her that R1 was going to be a problem, R1 was asking the CNAs for sexual favors, so she notified E1. E3 verified that E1 spoke to R1 at around 9:00 am. At around 10:30 am E6 notified E3 that R2 was found lying	F9999		

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F9999	Continued From page 12 in R1's bed and she was naked from waist down. During the interview with E3 on 5/22/09, E3 also stated wherever R1 would be placed he would be dangerous and the worst decision was placing him on the "Memory Loss" unit. E3 further stated that the residents on the "Memory Loss" unit had severe dementia and Alzheimer's disease and these residents cannot defend themselves. E3 also confirmed that R2 was not capable of giving consent for sexual intercourse and needs staff assistance for transfer. E3 further stated that R2 was not capable of defending herself by fighting physically with R1. E3 verified that both R1 and R2 resided on the "Memory Loss" unit. E1 (Administrator) was interviewed on 5/15/09 at around 3:26 pm. E1 stated that on 5/7/09 at around 9:00 am E3 notified him that R1 was making inappropriate sexual remarks to the CNAs, so E1 immediately talked to R1 and told him that the remarks he was making to the staff would not be tolerated. R1 stated he was sorry. E1 further stated that he went back to the staff and asked them to notify him if R1 made any further comments to them. E1 verified that other than talking to R1 there was no intervention done because in his experience he had not seen any verbal comment turning into a sexual predator. E1 also stated that he was not aware of R1 grabbing E7's forearm and leaning to kiss her until after the incident. A review of Z1's (Detective) investigation and interview with Z1 on 5/14/09 at around 1:40 pm showed that R1 admitted asking the employees for sex and that he was turned down by them. R2 was in a wheelchair along the hallway. R1 wheeled R2 into his room which was	F9999		

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F9999	Continued From page 13	F9999		

approximately 15 feet away. Once in his room, R1 closed the door and removed R2 from her wheelchair and laid her on the bed. R2 was lying across the bed on her back. R1 removed R2's pants, and ripped off her diaper. R1 then inserted his penis into R2's vagina and ejaculated inside her vagina and this went on for 1 minute. Then R1 put his clothes on and that was when E9 opened the door and observed R2 on the bed naked from her waist down. R1 was apologizing for the incident and did not want his wife to know about it.

E6 (Nurse - day shift) was interviewed again on 5/22/09 at around 9:10 am. E6 stated that the capacity of "Memory Loss" unit was 50 residents and they were 39 female residents residing on the unit out of which 24 female residents were at high risk for sexual abuse.

2. R2 is a 71 year old who was readmitted to the facility on 9/22/07 with diagnoses including Cerebral Vascular Disease, Aphasia, Hemiplegia, Malfunction of Vascular Device, and Dementia. R2's most recent Minimum Data Set (MDS) dated 5/13/09 documents that R2 has short and long term memory problems. The MDS also documents that R2's cognitive skills for daily decision making are moderately impaired (decisions poor, cues/supervision required). The MDS further documents that R2 needs total assistance of two plus (+) staff for all transfers. The review of clinical record also shows that R2 is on Hospice care.

R2's Cognitive Resident Assessment Protocol (RAP) dated 5/8/09 (start date) documents that R2 is alert with confusion. R2 displays with short and long term memory loss. R2 has diagnoses

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F9999	Continued From page 14 of Dementia and a past history of Cerebral Vascular Disease (CVA). R2 has poor daily decision making skills and requires cues and supervision from others. R2 requires assistance knowing what to do in regards to her daily schedule. R2 displays with communication deficit. R2 has difficult time making her needs known. R2 can make very simple and concrete needs known. R2 has very mumbled and unclear speech. This causes trouble for others to understand her. R2 also has some hearing loss. (A)	F9999		