STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145429	A. BUILDING ______ B. WING ______	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN WENTWORTH REHAB & HCC	**201 WEST 69TH STREET CHICAGO, IL 60621**

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F 363 SS=F	Continued From page 29 ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to met the recommended nutritional needs or folllow the menu for one meal. This failure lead to unapproved portion size being prepared for 216 of 216 residents residing in the facility. Findings include: The quantified recipe received 5/25/2010 at 9:30 AM, from dietary indicates portion size for the hamburger steak patty is 3 ounces of protien. On 5/26/2010 E9,cook, was asked to weigh the hamburger steak patty served for lunch, since it appeared to be a small portion to the surveyor. E9 weighed several different patties and the weight ranged from 2.2-2.5 ounces apeice. The serving size for a regular diet was one patty per E9. E9 looked at E10, dietary supervisor, stating the hamburger patty does not wegh enough. E10 instructed E9 to serve two hamburger patties for reguar diets and cook more patties, which cause multiple residents on all floors to receive there lunch late. On third floor the food arrived at 12:05pm with the last resident receiving his food at 1:20pm . The server on the third floor ran out	F 363		

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F 363	Continued From page 30 of meat twice and rice once during lunch. On 5/28/2010, E10 stated that the cook usually weighs the meat before serveing it but was nervous on 5/26/2010 and forgot to weigh it. E10 stated this is how they know portion sizes are correct.	F 363		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)6) 300.3240a) 300.3240c) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 31 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. 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. (Section 2-107 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) 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. (Section	F9999		

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3-612 of the Act)

These requirements are not met as evidenced by:

Based on staff, resident and physician interviews, review of the facility's abuse policy and record review, the facility failed to follow its own abuse policy after one resident outside of the sample, R32, made an allegation of sexual abuse against a male resident of the facility, R31. The facility failed to report and investigate in a timely manner this allegation. Since no reporting and timely investigation was done, the facility failed to protect the female resident from the alleged perpetrator who continued to reside in the facility. The male resident remained in the facility with access to all floors during the entire time of the facility's investigation. The facility's failure to follow it's Abuse policy has the potential to affect all 217 residents in the facility.

Findings include:

On 4/21/10, during a Care Plan Conference, R32 informed staff that she had been inappropriately touched sexually by another resident. On 4/26/10 the facility began to investigate the allegation. During the investigation, R31 remained in the facility and according to staff continued to have access to all floors of the facility.

When interviewed on 4/30/10, R32 informed the surveyor that she had informed staff of R31's inappropriate sexual advances during the care plan conference; that he had put his finger into her vagina one night. As stated by R32, she had been sitting on the side of the bed when R32 walked by and came back and said give me a

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F9999	Continued From page 33 kiss. I told him to get out of here and he started "slobbering on me and kissing me and put his hand in my vagina, hurting me and told me 'Your'e gonna give me this' I was scared." R32 denied having any romantic relationship with R31; that they were friends and would smoke together. Review of both R32's and R31's facility record reveals that there is no mention in R32's record about the incident other than a Social Service Note dated 4/21/10 which states that Social Services was informed of the sexual abuse allegation and the interview of R32. The most recent Physician Note in R32's record is dated 4/29/10 after the facility was informed of the alleged incident. The note does not mention the issue at all. The same occurred in R31's facility record with there being a Social Service Note dated 4/21/10 which states that Z4 (Psychiatrist) was to be notified and a second note dated 4/25/10 which indicated that R31 was to be seen by Z4 on 4/28/10. As of 4/30/10 R31 has not been evaluated by Z4 or any other Psychiatrist. E17 (Assistant Director of Nurses) was interviewed on 4/30/10 at approximately 1:00PM. E17 stated that she first learned of the incident from R32's family on 4/26/10. E17 informed E1 (Administrator) who in turn met with E3 (Social Services) and E5 (Resident Care Coordinator). They in turn interviewed R31 about the allegation, but he denied the allegation. R31 was informed that he should not go to any other floor. E5 continued on to say that R32 goes to first floor to visit friends and that R32 and R31 used to be friends.	F9999		

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F9999	Continued From page 34 First floor nursing staff was interviewed and E16 stated that R31 comes and goes in and out of the facility and does go to the second floor. E16 stated that she had been unaware of the resident's not being allowed to the 2nd floor until informed by the surveyor in this interview. When interviewed 4/30/10, E1 (Administrator) stated that the facility did conduct an investigation regarding R32 and the allegations against R31. E1 admits that R31 was not sent out to the hospital for evaluation after the allegation was made. E1 stated that R31 was informed that he was not allowed to go to the 2nd floor. A psychiatric evaluation was to be done. As of 5/5/10 the psychiatric evaluation has not been done. E1 also gave the surveyor a copy of the Incident Report Notification dated 4/26/10 and a copy of the written investigation re: the allegation involving the two residents. The investigation indicated that a Risk for Abuse Assessment and care plan would be initiated for R32. As of 4/30/10 this had not been done. It also indicated that R31's behavior would be care planned; as of 4/30/10 the information was not present on the care plan, but was on 5/5/10 and had been dated 4/21/10. On 4/30/10 at 12:50PM Z4 (Psychiatrist) was interviewed regarding R31 and stated that he'd been at the facility the prior day to see residents and that E9 (Social Services) had informed him of the allegation against R31 as he was "wrapping up his visit." Z4 admits not examining/assessing the resident and stated that he probably would have taken time to assess R31 had he known more details, but he was	F9999		

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F9999	Continued From page 35 given to understand that it had been an accusation, but nothing founded. Z4 stated that he would expect a resident to be transferred to the hospital for a psychiatric evaluation if that type of allegation is made. On 5/5/10 this surveyor interviewed, E5 (Patient Care Coordinator). E5 was identified as one of the persons responsible for conducting Minimum Data Set (MDS) and care plan reviews. E5 admitted that on 4/21/10 during the care plan conference, R32 informed him and E3 (Social Services) of the alleged occurrence with R31. The surveyor asked E5 to provide an up to date copy of R31's care plan which was done. On 5/7/10 at 11:45AM, Z7 (Physician) was interviewed regarding R31 and the allegation and stated to the surveyor that he had not previously been informed of the allegation made against R31, by R32; that the surveyor's mention of it was the first time he had heard it. Z7 stated that the issue should have been addressed by the nurses and the physician. When asked how often he sees R31, Z7 stated monthly and informed the surveyor that at the last visit the resident had not been very oriented although he had been calm and alert. When asked by the surveyor if he expected that R31 should have been transferred to a hospital for psychiatric evaluation, Z7 emphatically stated that R31 "Absolutely should have been sent to the hospital for a psychiatric evaluation." Z7 ended the interview by informing the surveyor that as soon as he finished the current phone call he would immediately contact the facility to follow up. On 5/25/10, during the initial facility tour, surveyors observed R31 as the resident entered	F9999		

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the 4th floor locked Alzheimer's Unit. The resident was also observed in the Alzheimer's Dayroom interacting with the other residents during an activity. R31 resides on the first floor. Staff interviewed on 5/28/10 stated that R31 does occasionally come into the Alzheimer's Unit.

During the course of this survey, the facility presented the surveyors with an identified list of those residents that had been assessed as at risk. According to the list provided to the surveyors, the Alzheimer Unit has 8 residents that have been identified as at risk for abuse. The Dementia Unit, also on 4th floor has 9 female residents that have been identified as at risk. The first floor has 7 female residents identified as at risk for abuse.

The facility's policy "Abuse Prevention Program Facility Policy requires staff to "Immediately" protect residents involved in identifying reports of possible abuse. The policy also requires that "Residents who allegedly mistreated another resident will be removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care, approaches and placement,considering his or her safety, as well as the safety of the other residents and employees of the facility.

(A)