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	14G365	A. BUILDING _____ B. WING _____	C 08/18/2010

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ALDEN VILLAGE NORTH	7464 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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W 149	Continued From page 8 actions to take if they are identified will be included in the new hire orientation packet. 6. Abuse and neglect training including recognizing signs of sexual abuse will be conducted quarterly. While the Immediate Jeopardy was removed on 08/17/10 at 11:55 AM, the facility remains out of compliance as the facility has not had the opportunity to fully implement and evaluate the effectiveness of the plan.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.620a) 390.1030c) 390.1030j)1) 390.3240a) Section 390.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 390.1030 Physician Services	W9999		

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W9999	Continued From page 9 c) The resident shall be seen by a physician as often as necessary to assure adequate medical care. (Medicare/Medicaid requires certification visits.) j) Physician Notification 1) The facility shall immediately notify the physician of any significant accident, injury, or unusual change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 390.3240 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) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure clients are not subjected to sexual abuse and are evaluated by a physician in a timely manner when the facility failed to: A. Have a formal system in place to ensure staff recognize suspected cases of sexual abuse. B. Have R11 seen by a physician or sent to an emergency room for immediate care and treatment in a timely manner. Findings include: According to information on the facility's	W9999		

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W9999	Continued From page 10 Inspection of Care form dated 10/30/09 the facility is home to 91 individuals. Most of the individuals are extremely vulnerable and have medically complex issues. The majority of them rely completely upon staff to address their medical needs, as well as their ADLs (Activities of Daily Living). The residents reside in a facility with 3 floors. The 2nd and 3rd floors are currently occupied. Of the 91 residents, 85 of them function at a Profound level of Mental Retardation. There are 3 residents functioning at the Severe level, 1 Moderate and 1 Mild. The residents range in age is between 1 to 60 years old. There are 32 residents who are fed by a gastrointestinal tube on a continuous basis. 82 residents in the facility are non-ambulatory and use a wheelchair. Of the 82 residents in wheelchairs, 59 are unable to propel themselves. 70 residents are non-verbal and must rely upon staff to anticipate their needs. 7 residents have tracheostomies. 8 residents are ventilator dependent. In addition to tracheostomies and ventilators, there are 5 other residents that receive oxygen on a continual basis. According to the medical record, R11 is a 16 year	W9999		

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W9999	Continued From page 11 old female with diagnoses including Severe Mental Retardation, Quadriplegic, Cerebral Palsy, Encephalopathy, Seizure Disorder and Scoliosis. She is incontinent of bowel and bladder and requires total staff assistance for all ADLs (Activities of Daily Living). R11 is non-ambulatory and is unable to propel her wheelchair without staff. R11 is also non-verbal and communicates through gestures, eye gaze and facial expressions. R11 is also provided nutrition through a gastrointestinal tube. Review of an incident report completed on 05/02/10 at 7:15 PM by E2, RN (Registered Nurse) noted that while E3, CNA (Certified Nurses Aid) was giving a shower to R11 she noticed blood in the vaginal area. Upon assessment E2 noticed a "cut" measuring 1.5 cm by 1 cm by 1.8 cm deep. E2 then cleansed the area and called Z1 (physician), E1 (administrator), E5 (director of nursing/DON) and R11's family. E2 was interviewed by surveyor on 08/03/10 at approximately 3:40 PM in the T.V. room on the first floor of the facility. E2 stated that she was scared when she saw the "wound" on 05/02/10. E2 then described the injury as a "cut" to the lower part of the vagina on the left side. E2 also stated that R11 did not appear to be in any distress or pain, she was not crying and there was no bruising or swelling to the inner thighs or vaginal area. E2 further stated that when R2 is upset or in pain she usually cries. When she called the doctor (Z1), he told her that maybe it was her menses and to just put a pad on her and we will send her out tomorrow. E2 then called E1 (administrator) and relayed to her what the doctor said.	W9999		

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W9999	Continued From page 12 E1 was interviewed on the afternoon of 08/03/10 at approximately 3:00 PM in her office. E1 stated that she was notified of the incident by E2 around 8:00 PM on 05/02/10. E2 told her that the CNA had noticed some blood on R11 that looked like a small skin tear or scratch to the vaginal area. E4 said to just monitor R11. E1 further stated that the next day she and E5 (D.O.N.) examined R11 at around 11:00 A.M. E1 stated that there was no bleeding at the time but the injury looked unusual. E5 stated that the injury was not jagged but like a paper cut that was not readily apparent unless the area was assessed more closely. E5 also stated that the physician was notified again at this time (approximately 11:30 AM) but was not available to see R11. The medical director was then called shortly after 11:30 AM and said to send her out to the hospital. Review of the Emergency Transfer Form and nurses notes reflected that R11 was not transported to the hospital until 4:30 PM on 05/03/10. Review of the Emergency room chart dated 05/03/10 at 5:50 PM noted that R11 was admitted to the hospital with a diagnosis of perineal laceration and urinary tract infection. A rape kit was completed and a summary of findings from her exam completed by Z2 (E.R. nurse) are as follows: Healing laceration to posterior forchette 5-7 (position 5 and 7) with skin flap abraded area at 11 o'clock appears as possible hymenal tear. Speculum exam deferred due to pt. developmentally delayed and contractures. External exam only.	W9999		

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W9999	Continued From page 13 R11's discharge summary completed by Z3 (hospital physician) stated in part, "social work/police/ DCFS continuing to follow patient for high suspicion of sexual abuse." Z1 (attending pediatrician) was interviewed by phone on 08/09/10 at approximately 11:00 AM. When asked why R11 was not sent to the hospital until the day after her injury was discovered he replied, "It sounded like a routine matter, could have been menstrual flow, nothing lead me to believe more was going on. I heard later that it may have been a scratch, I don't think I was told that initially. I was lead to think it was pretty minor." Z1 further stated that he just assumed that R11 went to the hospital the next morning (05/03/10) after the injury was discovered as per his orders. E1 was interviewed again on 08/10/10 at approximately 3:00 PM in her office. E1 was asked why R11 was not sent to the hospital on 05/02/10 after the injury was discovered. E1 stated, "We did not send her out earlier because we did not suspect abuse or jump to conclusions." The facility's policy on Abuse Prevention dated 05/10 was reviewed and defines sexual abuse as the following: "Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault." Section 2 - Orientation for new employees includes the following topics: a. Sensitivity of resident rights and resident	W9999		

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W9999	Continued From page 14 needs. b. Staff obligations to prevent and report abuse, neglect and theft. c. How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff. d. How to recognize burnout, frustration and stress that may lead to abusive reactions to residents. e. What constitutes abuse (physical, mental, sexual, verbal), neglect and misappropriation of resident property. Section 4 - Identification This section discusses who should report occurrences of abuse or suspected abuse, injuries of unknown origin and the chain of command to be followed for reporting. However, nothing in the facility's policy discusses how the facility's staff are to recognize signs of potential sexual abuse of a resident and the appropriate action to be taken when a potential sexually abusive situation has occurred. On 08/16/10 at 10:15 AM E1 was re-interviewed by telephone. E1 was asked if the facility has a system in place to recognize signs of sexual abuse. E1 stated that staff do daily body checks on residents and look for changes in behavior and skin integrity. We also have an online training course that is assigned to staff on a quarterly basis. Facility documentation provided on 08/16/10 was reviewed and there was no information to indicate that the facility has a formal system in place to recognize and immediately act upon	W9999		