STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145453	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 12/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TERRACE OF MCHENRY REHAB	803 ROYAL DRIVE MCHENRY, IL 60050

(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 323	Continued From page 10 did not return to facility. 2. An investigation of the 10/21/10 incident between R1 and R2 was initiated on 1022/10 and completed on 10/27/10. 3. All staff were inserviced on 10/25/10 and on an ongoing basis, regarding what to do when sexually inappropriate or abusive behavior is witnessed, suspected or reported and on the facility abuse policy and procedures, particularly related to prevention, identification, protection, investigation and reporting of sexual abuse. 4. All resident behaviors were reviewed for displays of sexually inappropriate behavior or risk for abusing other residents. 5. As of 11/1/10, the facility has a new administrator who will oversee the implementation of this removal plan.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a) 300.3240d) 300.3240f) 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (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,	F9999		

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F9999	Continued From page 11 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 3-612 of the Act) These Regulations were not met as evidenced by: Based on record review, interview and observation the facility failed to protect 2 dementia residents (R2 and R3) from inappropriate sexual contact. R1 abused R2 sexually on 10/21/10 in an enclosed, unoccupied room on the Alzheimer's Unit. R1 had previously abused R3 sexually on 8/16/10, also on the Alzheimer's Unit. Findings Include: R1 was observed with his head between the legs of R2 on 10/21/10 by E5 (nurse's aide) in an enclosed, unoccupied room on the Alzheimer's unit per review of facility investigation dated 10/27/10. Review of medical records shows both residents are demented and unable to give consent as they have been given legal guardians. R2 wears a diaper, is non verbal and per chart review is severely cognitively impaired. Medical record does not reflect that this resident seeks out male companionship or has ever engaged in any sexual acting out while on the unit. R2 was noted to be tearful and crying at the time of the 10/21/10 event by E5 (CNA) in her written statement. Surveyor observation of R2 on 11/12/10 found R2 unable to communicate or	F9999		

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F9999	Continued From page 12 express her needs. R2 would not have been capable of consent nor able to remove her diaper independently. R2 was not sent out to hospital for any physical evaluation per phone interview with E1 (acting administrator) on 12/1/10. R1 remained in the facility for two days following this incident on 10/21/10. In the meantime, facility implemented every 15 minute checks for the two days. A similar situation was documented in R1's nurse's notes dated 8/16/10 in which the "cna (nurse's aide) reported to this NOD (nurse on duty) that during rt. (routine) rounds, found resident (R1) performing oral sex to female resident." This female resident was R3 per E2 statement on 11/12/10. R3 is also unable to give consent and has a legal guardian. Because facility failed to follow their abuse policy and do an abuse investigation, Surveyor is unable to document and substantiate what measures facility took after the abuse of R3. E2 (director of nursing) confirmed on 12/1/10 that there was no investigation nor had IDPH been notified of this inappropriate sexual contact that occurred between R1 and R3 on 8/16/10. E2 confirmed that R3 was not sent out for evaluation following the 8/16/10 incident nor had R2, following that incident of 10/21/10. (A)	F9999		