

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W 322	Continued From page 22 and uses gestures on rare occasions. R5's IQ is 18 and she functions at a level of 1 year and 9 months. R5's physician order sheet, dated 12/10, states "PAP smear yearly." The most current gynecology note, dated 9/22/09, states "unable to per form exam." E3 confirmed R5's record findings on 12/3/10 at 12 PM, and said she is not aware of any residents, other than R3 and R4, having a STD, however could not be certain since R5 has no record of a PAP smear or a gynecological exam. E1 confirmed the findings in R5's record on 12/3/10, at 4 PM. She said there is no past PAP smear or gynecological exam documented for R5, even in bulk file, because she is uncooperative.	W 322			
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.3240a) 350.3240c) 350.3240d) Section 350.620 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. 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.	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 23 Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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)</p> <p>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)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to implement their abuse and neglect policy for 2 of 2 residents (R3, R4) with newly diagnosed sexually transmitted diseases, and for 1 of 1 resident (R3) who made a sexual abuse allegation. This has the potential to affect the safety of 13 of 13 residents in the home (R1,2,3,4,5,6,7,8,9,10,11,12,13).</p> <p>The facility failed to:</p> <p>1) Implement protective measures to prevent further potential harm to R3 and R4, along with the other residents in the home (R1,2,5,6,7,8,9,10,11,12,13) while R3's and R4's positive test results of sexually transmitted diseases (STD) - first reported 10/5/10, and R3's sexual abuse allegation - reported 11/1/10, were</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 24 being investigated.</p> <p>2) Conduct thorough investigations regarding R3's and R4's test results, and R3's abuse allegation.</p> <p>3) Notify the Illinois Department of Public Health of R3's and R4's test results, and R3's abuse allegation.</p> <p>4) Notify R3's and R4's guardian promptly of the positive test results, and of R3's abuse allegation.</p> <p>Findings include:</p> <p>Facility policy titled "Investigative Committee #5.24, revised 11/08" states: "Abuse: The willful infliction of injury, unreasonable confinement, or punishment with resulting harm, pain or mental anguish. Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The Investigative Committee shall be responsible for the following: A. Identify, review and determine if alleged violations of rights, including abuse and neglect have occurred. C. To protect individuals from further harm. If the allegation is one of the following situations, the Administrator will contact law enforcement: Sexual abuse of an individual by a staff member, another resident, or a visitor. The facility administrator shall report the matter within 24 hours, and send a written report within 5 working days to the individual's representative, and to Illinois Department of Public Health (IDPH)."</p> <p>The census provided by the facility on 12/2/10</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 25</p> <p>indicates the following: R2, 4, 5, 8, 7, 8 and 10 function at the Profound level of Mental Retardation. R12 functions at the Severe level. R6 functions at the Moderate level, and R1, 9, 11 and 13 function at the Mild level. Six females and seven males reside at this home. The census was reviewed with E1 (Residential Service Director) on 12/3/10, at approximately 12:00 PM. E1 was asked which residents can communicate, either verbally or by gestures. She said that R1, 3, 6, 9, 11,12 and 13 can communicate, but the other residents, R2, 4, 5, 7, 8 and 10 are unable to communicate verbally, or by gestures, most of the time.</p> <p>A) According to the Individual Program Plan (IPP), dated 2/17/10, R3 is an ambulatory and verbal 63 year old female, with a diagnosis of Severe Mental Retardation. Her IQ is 36, her overall adaptive level of functioning is 4 years/2 months, and her supervision level is in home with staff. Her guardian is from the Office of State Guardian (OSG).</p> <p>R3's record contained a PAP result, dated 6/2/09. It included screening for the Human Papilloma Virus (HPV), which was negative - "Not Detected." However, the next annual PAP smear screening for HPV, dated 9/28/10, stated it is positive - "Detected." A Gynecologist's consultation report, dated 11/20/10, documented, "HPV +, PAP smear is negative. No treatment necessary. Return in one year."</p> <p>The record, including all progress notes and E3's (LPN) monthly nursing notes, dated 11/12/10, 10/13/10, and 12/3/10, did not address the positive test results and plan of care.</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 26</p> <p>E3 was interviewed on 12/3/10, at 11:30 AM and confirmed the record findings. She said that E1 had notified her of the initial (9/28/10), and repeated (11/20/10), STD results. E3 said she had not spoken to the doctors or the office nurse regarding the results. She confirmed the record does not address R3's newly diagnosed STD.</p> <p>B) According to the IPP, dated 7/19/10, R4 is an ambulatory, non-verbal, 54 year old female with a diagnosis of Profound Mental Retardation. Her IQ is < 36, her overall adaptive level of functioning is 1 year and 6 months, and she occasionally communicates by gestures. Her level of supervision is in home with staff and her guardian is from the OSG.</p> <p>R4's record contained a PAP result, dated 7/24/09. It included screening for Chlamydia, which was negative - "Not Detected." However, the next annual PAP smear screening for Chlamydia, dated 9/28/10, stated it was positive - "Detected." The Gynecologist's note, dated 9/28/10, stated, "Normal external genitalia, atropic mucous. The following repeat exam and test result, both dated 11/20/10, document the Chlamydia result as positive. The Gynecologist's note, states, "Vaginal exam reveals a yellow purulent discharge which is consistent with Chlamydia. Patient was re-cultured. Suggest Z pack [antibiotics]."</p> <p>R4's record, including E3's (LPN) monthly nursing notes, dated 11/12/10 and 10/13/10, did not address the positive test results, plan of treatment, or the discussion to delay treatment until re-testing was done.</p> <p>E3 was interviewed on 12/3/10, at 11:30 AM.</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 27</p> <p>She confirmed R4's record did not address the newly diagnosed STD or the plan of care. E3 said that E1 had notified her of R4's initial (9/28/10) and repeated (11/1/10) STD test result.</p> <p>E1 (Residential Service Director) was interviewed on 12/2/10, at 2:45 PM. She stated she has been the RSD for approximately 6 months and confirmed the surveyor's findings in R3's and R4's records. E1 stated that she first became aware of R3's and R4's positive test results on 10/5/10, after they were faxed to her by the Gynecologist's office. According to E1, she then spoke to the Gynecologist and the office nurse, and a joint decision was made to have both residents retested to rule out any error. E1 said the decision also included not treating R4's STD until the second result was known, however she has no documentation of this discussion. She said the re-testing did not occur until 11/20/10, almost 2 months after the original test date of 9/28/10, because of scheduling. E1 said that she immediately notified E4 (Executive Director), E2 (Trainer) and E3 (Facility LPN) of the positive STD results, but has no reproducible documentation. She said she did not notify the Illinois Department of Public Health.</p> <p>On 12/6/10 at 12:30 PM, E4 confirmed he had been notified by E1 of R3's and R4's test results.</p> <p>E2 (Trainer) said on 12/2/10, at 3:15 PM, that E1 had spoken to her regarding R3's and R4's test results. E2 said the initial positive STD results, completed on 9/28/10, were not reported to IDPH because the facility was waiting for the repeated test results done on 11/20/10. She was unsure if IDPH was notified of the repeated tests. However, there is no documentation that IDPH</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 28 was notified.</p> <p>On 12/2/10, at 2:45 PM, E1 was asked about an investigation of the test results. She said that she started an investigation which consists of only staff and resident interviews. She confirmed she has no reproducible documentation of her conversations with the Gynecologist's office or with staff, including E2, E3 and E4, regarding the test results. E1 stated measures to ensure R3's and R4's safety, along with the rest of the residents, have not been implemented.</p> <p>R3's and R4's records include the positive test results, but do not include documentation addressing these results, either medically or administratively. There is not an incident report regarding these test results. E1 confirmed this during her interview on 12/3/10, at 4:00 PM.</p> <p>On 12/2/10, at 3:00 PM, E1 provided the investigation documentation to this surveyor and stated there were no other notations or reports at this time. The investigation consisted of only interviews. She stated there has not been a special team meeting (STM), or an Investigation Committee meeting, concerning these lab results. E1 said currently she is not aware of any other residents having STD's, however the charts still need to be reviewed. She said there is no definitive plan to test other residents at this time.</p> <p>All the residents' records were reviewed, however one of the six female's (R5's) record lacked a gynecological exam and PAP smear testing. R5's IPP, dated 11/23/09, states she is 42 year old ambulatory female who is unable to communicate verbally and uses gestures on rare occasions. R5's IQ is 18 and she functions at a</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 29</p> <p>level of 1 year and 9 months. R5's physician order sheet, dated 12/10, states "PAP smear yearly." The most current gynecology note, dated 9/22/09, states "unable to perform exam."</p> <p>None of the male charts (R7, 8, 9, 10, 11,12,13) contained STD testing. E1 confirmed this on 12/3/10, at 3:45 PM. She said R5's exams have been unsuccessful because she has been uncooperative in the past.</p> <p>C) While reviewing the STD test investigation interviews, this surveyor noted that Direct Service Persons (DSP's) (E6, E9) wrote on 11/1/10 that R3 made an allegation that at day training (DT), someone named [R] was touching her private areas, knocked her down and was laying on top of her and that she was scared.</p> <p>E1 was asked about this allegation on 12/3/10, at 12:00 PM. She said that staff notified her immediately on 11/1/10 and she went to DT that day. E1 stated that she interviewed only two female day training DSP's (Z6, Z7) assigned to R3's and R4's room, but not any of the DT residents. She said that she has not informed other DT staff, including DT administration of the positive lab results, or R3's allegation of sexual abuse. At this time, E1 said she is not sure if [R] is a DT staff or resident. She said there is a [R] part-time staff at DT.</p> <p>R3's record, including all progress notes, lacked documentation of this allegation of sexual abuse.</p> <p>E1 confirmed the above findings on 12/3/10, at 4:00 PM, and said she had notified E4 (Executive Director), E12 (Trainer) and E3 (Facility LPN), of R3's abuse allegation, however has no</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 30</p> <p>reproducible documentation. On 12/6/10, at 12:30 PM, E4 confirmed he had been notified of the abuse allegation.</p> <p>On 12/3/10 at 12:00 PM, E1 said that the provided investigation documentation (only staff and resident interviews) is for both occurrences- R3's and R4's positive STD test results, and R3's sexual abuse allegation. She stated that there has not been a Special Team Meeting, nor an Investigative Committee Meeting, to address R3's abuse allegation.</p> <p>As of 12/3/10, the facility's investigation consists of interviews with 5 of 7 home staff (DSP), 6 of the 13 residents, and 2 day training DSP's. E1 confirmed that even though she became aware of the positive test results on 10/5/10, the staff interviews occurred on 10/29/10 and 11/1/10, and the resident interviews range from 9/29/10 to 10/30/10. When asked why the investigation lacked interviews from the one night shift DSP (E7), and another home DSP (E8), E1 said she had interviewed E7, but had not yet documented it, and that E8 was not interviewed because she is new and has only worked at the home about 2 weeks. When asked for interviews with the other residents who can communicate (R12, 13), E1 said that she had interviewed them, but has no documentation.</p> <p>E7, female night shift DSP, was interviewed by this surveyor on 12/7/10, at 9:40 AM. She said that she never noticed any sexual interaction or inappropriate touching between staff and/or residents. She confirmed she is the night shift staff and that on her nights off, usually the weekends, E9 (PM male staff) covers her shift.</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 31</p> <p>E9 was interviewed on 12/7/10, at 3:05 PM. He stated that he was arriving for his assigned PM shift, and has been working PM's at the facility for approximately 1.5 years. E9 said that he occasionally worked nights before the past 2-3 months, but recently has been covering the weekend night shifts, sometimes alone, and sometimes with E1. He stated he has never been aware of inappropriate behavior between staff and/or residents.</p> <p>E1 was interviewed on 12/7/10, at 3:15 PM. She confirmed E9's statements. She stated that the only other male staff in the home (E10) works the PM shift and has been on vacation for about 2 weeks.</p> <p>Z5 (DT Coordinator) and Z6, Z7 (DT DSP's) were interviewed on 12/3/10, at 2:00 PM. Z5 stated there is not a resident with the name [R] at the DT site, but there is a part-time male staff named [R]. She said that only after R3's and R4's guardian from OSG (Z2) came to DT on 12/2/10, was she aware that there was some type of incident regarding R3 and R4. She said that only females (Z6,Z7) work in R3/R4's DT room, and only female staff take the ladies to the bathroom. Z6 and Z7 said R3 is independent going to the bathroom, but R4 needs assistance. Z5 said the staff [R] is rarely assigned to R3/R4's DT room, but never takes the ladies to the bathroom. This was confirmed by Z6 and Z7. Z5 said [R] has worked since 10/5/10 (positive lab tests for R3, R4), and since 11/1/10 (R3's allegation).</p> <p>Z2, (OSG/R3's and R4's guardian) was interviewed on 12/6/10, at 9:45 AM. She said that on 12/1/10, E1 notified her of R4's first Chlamydia test result, done on 9/28/10, and the</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 32</p> <p>repeated test, done 11/20/10. Z2 said that not until she went to the home on 12/2/10 was she informed of R3's allegation of sexual abuse. Z2 stated that not until today, when this surveyor informed her, was she aware of R3's positive HPV test result. She said she has known R3 and R4 for years and is not aware of any past positive STD results. However regarding R3's allegation of sexual abuse, Z2 said R3 has a history of fabricating stories. According to Z2, she interviewed R3 on 12/2/10 at DT and R3 said she likes the DT staff person [R] and would like him for a boyfriend, but that he never touched her in any way.</p> <p>R3's IPP identifies that she does have has a history of fabricating stories.</p> <p>R3 was interviewed by this surveyor on 12/3/10, at 2:15 PM in the DT office. She said that she does not have a boyfriend, is lonely and likes DT staff [R]. R3 said that [R] never kissed or touched her. R3 said that no-one ever touches her, or R4, inappropriately.</p> <p>R4 was interviewed at the DT site on 12/3/10, at 2:30 PM. She did not respond, except to look at this surveyor.</p> <p>E1 was interviewed on 12/3/10, at 3:45 PM regarding guardian (Z2) contact. She provided the following phone log entries; 9/30/10 + 11/11/10 + 11/23/10 = "Message left regarding [R3's and R4's initials]." 11/30/10 = "Z2 called back, needs a call back from E1." 12/1/10 = "Contact[ed] - Z2. Details of Conversation - [R3's, R7's, R4's initials]- test results - [R7] tracking." 12/2/10 = "Visit from Z2 - spoke about test results".</p>	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2010
NAME OF PROVIDER OR SUPPLIER TORRENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 223RD STREET SAUK VILLAGE, IL 60411		
(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	
W9999	<p>Continued From page 33</p> <p>During the interview, E1 was asked if there is additional documentation detailing Z2's notification. She said that there is only the log documentation. When asked about the delay of guardian phone calls, E1 said she left messages for Z2 to call back because Z2 was out of the office. E1 said she did not leave specific details in the messages, nor did she speak with anyone else at the OSG office.</p> <p>Z1 (R3 and R4's Primary Care Physician) was interviewed on 12/3/10, at 4:25 PM. He stated that he was not aware of the positive test results for R3 and R4. The record lacked documentation that Z1 was notified of these results.</p> <p>Z4 (Gynecologist) was interviewed on 12/6/10, at 11:25 AM and said that neither R3, nor R4, have histories of STDs. Regarding R3's HPV result; Z4 said HPV is a virus which R3 may have acquired years ago and that the test result can fluctuate between negative and positive throughout the years. However, regarding R4's Chlamydia result, Z4 said that Chlamydia is a STD which will always test positive once contact has been made, and the infection is transmitted sexually, especially in this case when a cervical swab is the site of infection. She said antibiotic treatment is needed for Chlamydia, and it would be a good idea to test all the residents residing at the home.</p> <p>(A)</p>	W9999			