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F 490	Continued From page 27 Assessment and Monitoring policy delineates the protocol for assessing and monitoring problematic resident behaviors. This policy was adopted by the facility on January 27, 2011, when new policy books from the Corporate Office were delivered. All residents with unmanageable behaviors are discharged from the facility in accordance with the Unmanageable Residents Policy that was adopted by the facility January 27, 2011, when new policy books from the Corporate Office were delivered. 9. The offending resident was never left alone after the offense unless he was in bed. He was on 1:1 observation while he was out of bed, and he was unable to transfer from his bed to the wheelchair without assistance. He was discharged to the hospital the same day as the offense, and has not, and will not, return to this facility. There were two residents involved in the incident. Both families were notified and both residents ' doctors were notified. The incident was reported to IDPH within 24 hours as required. An investigation into the incident was initiated and a final investigative report was filed with IDPH within 5 days. The Administrator called the Illinois State Police and proved them with reports of the incident. On February 25, 2011, the Administrator filed incident report #11-2068 with the Rock Falls Police Department by calling 911. This facility notifies the local authorities of all abuse incidents in compliance with our Abuse Investigations policy protocol which was adopted by the facility on January 27, 2011, when new policy books from the Corporate Office were delivered.	F 490		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 28 LICENSURE VIOLATIONS 300.510e) 300.610a) 300.1210a) 300.1210b)3) 300.1220b)2) 300.3240a) 300.3240f) 300.510 Administrator e) The licensee and the administrator shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regualtions according to the level of their responsibilities. 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility. These written policies shall be followed in operating the facility. 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.	F9999		

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F9999	Continued From page 29 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need fore further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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) 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	F9999		

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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 requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to thoroughly assess, monitor, and develop ongoing interventions for R5, a resident with a documented history of sexually inappropriate behaviors upon admission to the facility on 07/22/10. The facility neglected to follow their Abuse Policy and procedure by not modifying and implementing interventions to reduce and/or eliminate R5's unwanted physical/sexual touching of female staff and residents (R6 and R9). R5 continued to have sexually aggressive behaviors and make sexually suggestive comments to staff the entire time he was at the facility. The facility staff failed to follow their policy on abuse ensuring each incident was documented and reported. These failures resulted in R9 being sexually assaulted by R5 on 08/3/10 and R6 being sexually assaulted by R5 on 2/5/11.

This applies to 2 of 9 residents reviewed. (R6 & R9)

Findings include:

R5's Hospital History and Physical dated 07/13/10 states, "MENTAL STATUS EXAM: The patient is alert, oriented times three, cooperative...Thought process is logical and sequential...Memory and concentration grossly

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F9999	Continued From page 31 intact." The facility screened R5 prior to admission which showed R5 had a history of sexually aggressive behaviors. The transfer records from the previous skilled nursing facility (located in R5's current medical record) show Social Service notes dated 5/28/10 through 7/16/10 which document R5 repeatedly made, "inappropriate sexually comments" to the facility staff. A note dated 7/16/10 states, "Nurse was standing there and (R5) slapped nurse's butt." On 7/19/10 a (previous facility) note shows, "Informed wife that due to the most recent behaviors exhibited by (R5) facility would be initiating discharge procedures. Resident's wife agreed and chose voluntary discharge." The faciltiy identified R5 as having sexually aggressive behaviors, and did not develop a plan to prevent R5's sexually aggressive behaviors after being admitted to the facility. The January 2011 Physician Order Sheet shows R5 was admitted to the facility on 7/22/10 with diagnoses to include Cerebral Vascular Accident with left-sided Hemiparesis and Depression. The Current Minimum Data Set of 1/21/11 documents R5 to have physical (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal (threatening others, screaming at others, cursing at others), symptoms directed toward others. The same assessment documents R5's behaviors do not put him at significant risk for physical injury, do not significantly interfere with the resident's participation in activities, do not put others at significant risk for physical injury, do not significantly intrude on the privacy or activity of	F9999		

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others, or significantly disrupt care or living environment.

On 2/18/10 at 1:00 PM, Z1 (Primary Care Physician/Medical Director) stated, "(R5) is oriented most of the time. He knows what he is doing. His mentation is ok. He can tell me his symptoms and what he wants. I am not aware of any previous sexually inappropriate behaviors. The facility should notify me of any such behaviors."

The facility Initial Psych/Social History dated 7/22/10 states, "Presence of Mood/Behavior Prior to Admin: sexual/inappropriate behavior... He had recent aggressive behavior towards staff at other nursing home."

On 2/24/10 at 9:05 AM, E1 (Administrator), said, E13 (Admission/Marketing), told the previous administrator (Z2) R5 should not be admitted to the facility.

On 2/24/10 at 9:30 AM, E13 (Admission/Marketing) stated, "The initial referral for (R5) came to me. He had been at another nursing home. I called to find out why (R5) wasn't going back, and I was informed he was very aggressive: he had been touching employees inappropriately and he had now started touching residents. I told the Administrator (Z2) (R5) was not a good resident for us to take; there were too many red flags. (Z2) said we are not going to pursue (R5's) admission to the facility. The next morning, (R5) had been admitted to the facility. I asked why (R5) had been admitted and (Z2) said she had went and assessed (R5), picked him up, and

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brought him back to the facility." E13 continued, "(R5) made a comment to me and I reported to the Administrator. (R5) said, 'I want to lick your p---y.' When I told (Z2) she told me, Let it go it's no big deal. Just laugh it off. He has said things like that to me before." E13 was visibly upset during this interview and began crying.

On 8/04/10 R5 sexually assaulted R9. R5's nursing note on 8/3/2010 states, "Pt observed by staff inappropriate touching (R9's) chest. Immediately staff intervened, redirecting resident. Instructed behavior inappropriate. Removed from area. Episode occurred at approximately 7:15 PM. Administrator notified of (R5's) behavior."

On 2/22/11 at 3:15 PM, R9 stated, "(R5) touched my boob. It happened twice. I told him to keep his hands off me or I'd stab him with my fork. I reported the incident to the CNAs and (E19, Licensed Practical Nurse). It made me feel low. He is a creep, and I'm not the only one he did it to." R9 was visibly upset and began crying during the interview.

The incident summary dated 8/4/10 states, "He is not to be left alone with female residents, eats meals at a table with other male residents, and female staff are instructed not to give care alone."

A sexual assault by R5 to R6 is documented in a facility occurrence report dated 2/5/11 at 7:10 AM, stating, "Resident (R5) was being sexually inappropriate with other resident (R6)."

The facility summary report dated 2/5/11 states,

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"It is reported that sexually inappropriate behavior occurred insofar that male resident (R5) inappropriately touched the breast of female resident (R6) while in the dining room."

On 2/18/11 at 1:05 PM, E10 (Cook) stated (on 02/05/11), "I opened the door between kitchen and dining room and (R5) was on (R6's) lap. (R6) was in her reclining chair. When I came around to the front of them, I saw (R6's) shirt was pulled up. (R5) had his mouth on (R6's) right breast and his right hand on her left breast. I said (R5's) name in a loud short tone. He looked up at me and moved back quickly. (R5) is alert and he knows what he is doing. I think he knew what he was doing; all he did was smile. It didn't make me feel very good. I saw (R6) about 15 minutes prior and she was at another table. (R6) is unable to move herself so (R5) had to of pulled her from her table to the back of the dining room." E10 explained R5 and R6 were the only residents in the dining room and there were no staff to supervise the dining room at that time.

On 2/18/11 at 12:40 PM, E14 (Social Service Director) stated, "We sent (R5) out for a psychiatric evaluation. If (R6) sees this man she would always be frightened. As a woman, if I saw a man who touched me without permission, I'd be afraid. She would look at him and wonder why is this man still here after what he did to me."

The facility did not have any care plan addressing R5's history of aggressive/sexual behaviors, a plan to monitor or institute measures to prevent R5's behaviors until 8/11/10, eight days after the first sexual assault. R5 continued his aggressive/sexual behaviors and the facility

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did not follow identified interventions or develop new approaches to prevent R5's continuous sexually aggressive behaviors.

On 2/22/11 at 1:15 PM, E14 (Social Service Director), stated, "I knew (R5) had physical and verbal sexual behaviors prior to admission. The plan of care was written on 8/11/10, and there were no changes to approaches in the the plan of care from 8/11/10 until discharge, except for psychiatric referral. He was to be supervised, in a public area. That was the plan."

The facility behavior charting shows, "Target behaviors: History of Sexually Inappropriate behavior and History of Physical Aggression." The same charting documents the following frequence: 5 episodes in 7/10, 16 episodes in 8/10, 21 episodes in 9/10, 28 episodes in 10/10, 31 episodes in 11/10, 9 episodes in 12/10, 11 episodes in 1/10, and daily episodes from 2/1/11 until 2/5/11, when R5 was discharged. There were no new behavioral interventions for nearly six months from August 2010 until February 2011.

R5's nursing note dated 7/22/10 at 12:25 PM, states, "When resident put to bed trying to pat CNA's (Certified Nursing Assistant) bottom and sexual talk, 'Baby your good.' 15 minute watch due to sexual and aggressive behavior."

R5's nursing note on 8/3/2010 states, "Pt observed by staff inappropriate touching (R9's) chest. Immediately staff intervened, redirecting resident. Instructed behavior inappropriate. Removed from area. Episode occurred at approximately 7:15 PM. Administrator notified of

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(R5's) behavior. Pt remains on 15 min checks."

On 2/18/11 at 2:00 PM, E8 (CNA), stated, "(R5) made inappropriate comments to me almost everyday. He asked me how many kids I had. I answered none and (R5) stated, I'd give you some if you wanted them. He liked to feel; he would try to grab my butt. He knew what he was doing, and he never apologized."

On 2/18/11 at 2:05 PM, E7 (CNA), stated, "(R5) made sexual comments daily. He would look down your shirt and say you have a nice butt. He tried to grab your butt. He told me I needed to spread my legs. I reported to my nurse, but it did not improve. I think he understood what he was doing."

On 2/18/11 at 2:15 PM E5 (CNA), stated, "(R5) made inappropriate sexual comments the entire time he was in the facility. He said to me 'Can I suck your nipples; Let me suck that p---y; Come here let me play with you; Let me f--k you.' R5 touched my butt, he would reach for my front private area, and he has grabbed my boob. I reported it to the charge nurse, and put in the behavioral book. Sometimes I was too busy to put it in the behavioral book, I would tell co-workers to watch out. He knew what he was doing. I am not surprised it happened to a resident. They didn't do anything when it happened to us."

On 2/18/11 at 2:20 PM, E4 (CNA), stated, "(R5) made inappropriate comments. The first time was back in August, shortly after he was admitted. He said to me 'I have sixty dollars and I want to see your boobs.' He ran his hand

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across the right side of my butt. I documented the behavior in the behavior tracking, and I reported it to the nurse. The nurse told me to document what happened. I would redirect (R5) and tell him his behavior was inappropriate, and I didn't appreciate it. He said he was sorry. He knew what he was doing. When he told me he had sixty dollars. I told him I didn't appreciate it, he said 'please don't tell my wife.'"

On 2/22/11 at 2:35 PM, E17 (CNA), stated, "(R5) made comments of a sexual nature. and it happened repeatedly. It was close to (July 2010) when he was admitted the first time he made comments. (R5) stated he wanted to eat my p---y, and he wanted to play with my p---y. He told me he wanted to grab my fat butt. He would then move his fingers toward me. He grabbed my butt once. I told him it was inappropriate and he didn't say anything. I reported it to (E9 - Charge Nurse). I would tell the nurse every time it happened. One nurse told me (R5) said the same thing to her. I think he knew what he was doing because I told him his wife wouldn't like it and he said, 'she wouldn't care.'"

On 2/20/11 at 2:50 PM, E7 (CNA) stated, "(R5) would always look down your shirt. He wanted to smack my bottom. He would say it looked like a basketball. He would grab your rear end when you turned around. He did it about ten times. I would tell him not to do it. The nurse knew it was happening. Everyone knew it was happening. The nurses were aware of it. I didn't report it every time because nothing changed. The administrator was aware of it, he was thrown out of the last facility for it. We were aware of it from day one. I am not surprised he did it to (R9) in

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August of 2010. Nothing changed after being reported; he was on 15 minute checks. He was not supposed to be alone with another resident. We had two other residents on 15 minute checks, and it was hard."

On 2/22/11 at 1:30 PM, E15 (LPN, Charge Nurse), stated, "(R5) said something, I don't recall what exactly. I redirected him. It was never reported to me that he had inappropriate behaviors. I was not aware of any inappropriate behaviors since I started in October 2010."

On 2/22/11 at 3:45 PM, E11 (LPN, Charge Nurse) stated, "(R5) made comments and would grab at my behind. He would point at his privates and say 'why don't you play with this.' The CNAs would report his behaviors to me. I reported (R5's) behaviors and comments to both the Director of Nursing and Administrator. All staff knew about it. I remember the incident with (R9). He was always to be supervised; (R5) should not have been alone with a female resident."

The undated facility policy titled, Abuse Prohibition-Abuse, Neglect, and Misappropriation of Resident Property, states, "When it is determined that there is a reasonable cause for possible mistreatment, the administrator or designee will appoint a person to take charge of the investigation. A thorough investigation will initiated immediately for all alleged incidents of abuse. The investigation will involve staff members, residents, family, and visitors who have potential knowledge of the incident or its circumstances. Written, signed statements from witnesses, if any, will be provided." (p. 8) The facility did not follow the abuse policy and