STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIBSTRA HOUSE	**271 EAST 161ST STREET SOUTH HOLLAND, IL 60473**

(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 000	INITIAL COMMENTS COMPLAINT INVESTIGATION Complaint #1192523 IL 54146	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility's governing body failed to provide adequate direction for staff to promote the safety for 1 of 1 clients, R1, who alleged a staff person had sexual contact with the client , due to the failure to immediately report this allegation to the Administrator and place sufficient safeguards for the clients. The facility failed to ensure: 1. The alleged staff did not have contact with this client or others during the course of the investigation 2. Direct care failed to immediately report the allegation of sexual contact to the Administrator 3. Medical personnel assessed R1 for evidence of sexual contact 4. During the course of the investigation the alleged staff was allowed to transport and attend an activity outside the facility with clients from this facility 5. The facility policy for abuse and neglect includes any medical evaluation or the protection of clients related to contact with the alleged perpetrator. Findings include: Refer to deficiencies cited at:	W 102		9/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 W104 - The governing body and management exercise general policy and operating over facility W122 - Condition of Participation - Client Protections W331 - Clients must receive nursing service in accordance with their needs	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure their policy on abuse and neglect included what actions should be taken: 1. when an allegation of sexual abuse is made to evaluate the clients status medically 2. To address a suspended employee who is the subject of alledged abuse or neglect, allowed contact with clients during the course of the investigation impacting 1 of 1 R1, who alleged staff had sexual contact with her and had the potential to impact R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16. Findings include: 1) R1, per the Physician's Orders Sheet dated 7/28/11, is a 57 year old female whose diagnoses include Mild Mental Retardation and Down Syndrome. The facility policy titled Abuse and Neglect dated	W 104		9/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 2 1/31/08 defines Sexual Abuse as, "Any act of sexual contact, sexual penetration, sexual coercion, or sexual exploitation of an individual. Sexual abuse includes, but is not limited to: fondling, body exposure, rape, engagement in sexual acts with the persons served, sexual harassment, etc." The General Procedure section states, "Obtain copies of documents or records that pertain to the incident, including written statements, medical reports, individual records, photographs, and any applicable evidence." The policy does not define what specific medical action is to be taken when an allegation of sexual abuse occurs. Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported E5, Direct Service Person (DSP) had touched her private areas on 8/6/11 including her breasts and vaginal area. Record review of R1's file does not contain any information R1 had been evaluated by a medical person (nurse or physician).. Interview with E1, Qualified Service Professional, on 8/19/11 at 10:45am when asked if R1 had been seen medically stated, "I don't believe so." Interview with E2, Executive Director, on 8/19/11 at 2:25pm acknowledged the facility policy on abuse/neglect does not address specifically what medically action is to be taken in the event of a sexual allegation. 2) The facility policy on Abuse and Neglect dated	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 3	W 104		

1/31/08 under PROCEDURES C. General Procedures, "Any employee accused of abuse or neglect will be immediately suspended with pay until completion of the investigation."

The policy does not address the issue of contact between a suspended employee and residents nor does it address staff actions if a suspended employee is on facility grounds.

On 8/31/11 at 10:45am E7, Administrator, informed surveyor E5, Direct Service Person (DSP), had been terminated. E7 stated E5, an employee who was on suspension for alleged sexual abuse had been on facility grounds, drove the facility bus with the residents and E9, DSP, to church on 8/28/11, was in the church with the residents and drove the bus back to the facility before leaving facility grounds. E7 was asked if E5 had been told he is not to have contact with the residents. E7 stated in E5's first suspension on 8/9/11 he was told not to come back but on the second suspension on 8/12/11 pending the results of an independent investigation E7 told him he is off the schedule. E7 stated he didn't specifically tell him he is not to have contact with the residents. E7 was asked if the facility policy on Abuse and Neglect defines a suspended employee's contact with the residents. He stated, "No, it is not that specific." E7 was asked if staff have received training on what to do if a suspended employee comes on facility grounds. E7 stated the 2 staff involved, E4 and E9, he believes received training from E2, Executive Director. Regarding the facility's other staff, E7 stated he discussed in general terms the nature of E5's termination in violating the terms of the suspension but he did not discuss the issue of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 4 suspended employee contact with residents or what staff are to do if a suspended employee comes on facility grounds.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility's governing body failed to provide adequate direction for staff to promote the safety for 1 of 1 clients R1, who alleged a staff person had sexual contact with the client , due to the failure to immediately report this allegation to the Administrator and place sufficient safeguards for the clients. The facility failed to ensure: 1. The alleged staff did not have contact with this client or others during the course of the investigation 2. Direct care failed to immediately report the allegation of sexual contact to the Administrator 3. Medical personnel assessed R1 for evidence of sexual contact 4. During the course of the investigation the alleged staff was allowed to transport and attend an activity outside the facility with clients from this facility 5. The facility policy for abuse and neglect includes any medical evaluation or the protection of clients related to contact with the alleged perpetrator. This resulted in an Immediate Jeopardy. Findings include: On 8/31/11 at 12:20pm an Immediate Jeopardy was identified to have begun on 8/21/11 when a	W 122		9/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 122	Continued From page 5 suspended employee for alleged sexual abuse, E5, Direct Support Person (DSP) was on facility grounds prior to completion of the investigation. The 2 staff present E4 and E9, DSP's, did not report the presence of E5 on facility grounds to the appropriate personnel. E5 drove the facility bus along with R1, R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16 and E9 to church. E5 attended church with the residents and E9 and drove the bus back to the facility before leaving the facility grounds. This lack of ensuring a suspended employee for alledged sexual abuse did not have contact with facility residents potentially jeopardized the safety and well being of the residents. This resulted in an Immediate Jeopardy. E7, Administrator, was notified of the Immediate Jeopardy on 8/31/11 at 12:20pm. On 9/6/11 at 2:37pm E7, Administrator, was notified that the Immediate Jeopardy was removed. Refer to deficiencies cited at: W104 - The governing body and management exercise general policy and operating over facility W149 - Develop and implement written policies prohibit abuse W154 - Must have evidence all alleged violations are investigated W155 - Must prevent further potential abuse W331 - Clients must receive nursing service in	W 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 122	Continued From page 6 accordance with their needs	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility's governing body failed to provide adequate direction for staff to promote the safety for 1 of 1 clients, R1, who alleged a staff person had sexual contact with the client , due to the failure to immediately report this allegation to the Administrator and place sufficient safeguards for the clients. The facility failed to ensure: 1. The alleged staff did not have contact with this client or others during the course of the investigation 2. Direct care failed to immediately report the allegation of sexual contact to the Administrator 3. Medical personnel assessed R1 for evidence of sexual contact 4. During the course of the investigation the alleged staff was allowed to transport and attend an activity outside the facility with clients from this facility 5. The facility policy for abuse and neglect includes any medical evaluation or the protection of clients related to contact with the alleged perpetrator. Findings include: On 8/31/11 at 12:20pm an Immediate Jeopardy was identified to have begun on 8/21/11 when a suspended employee for alleged sexual abuse, E5, Direct Support Person (DSP) was on facility grounds prior to completion of the investigation.	W 149		9/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 7 The 2 staff present E4 and E9, DSP's, did not report the presence of E5 on facility grounds to the appropriate personnel. E5 drove the facility bus along with R1, R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16 and E9 to church. E5 attended church with the residents and E9 and drove the bus back to the facility before leaving the facility grounds. This lack of ensuring a suspended employee for alledged sexual abuse did not have contact with facility residents potentially jeopardized the safety and well being of the residents. This resulted in an Immediate Jeopardy. E7, Administrator, was notified of the Immediate Jeopardy on 8/31/11 at 12:20pm. On 9/6/11 at 2:37pm E7, Administrator was notified the Immediate Jeopardy was removed. R1, per the Physician's Orders Sheet dated 7/28/11, is a 57 year old female whose diagnoses include Mild Mental Retardation and Down Syndrome. 1) The facility policy titled Abuse and Neglect dated 1/31/08 defines Sexual Abuse as, "Any act of sexual contact, sexual penetration, sexual coercion, or sexual exploitation of an individual. Sexual abuse includes, but is not limited to: fondling, body exposure, rape, engagement in sexual acts with the persons served, sexual harassment, etc." The Procedure section states, "If an employee observes, is told of, or has reason to believe and instance of abuse or neglect has occurred he/she is required to immediately report the allegation to the Program Administrator or designee, who shall then ensure	W 149		

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W 149	Continued From page 8	W 149		

the safety of the persons served and facilitate the removal of potential threat or harm: including removal of accused employee if appropriate."

Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported to E5, Direct Service Person (DSP) had touched her private areas on 8/6/11.

On 8/18/11 E1, Qualified Service Professional, (QSP) at 12:24 pm was asked about the allegation of sexual abuse made by R1. E1 stated R1 told her E5 touched her breasts and vaginal area in the medication room on Saturday (8/6/11) morning and took naked pictures of her with his cell phone in her bedroom at 11:15am. E1 said E5 was suspended on 8/8/11 but had worked on Saturday and Sunday, 8/6/11, 8/7/11, from 7:00am thru 3:00pm. E1 stated the investigation stated R1 at 3:30pm on 8/6/11 was heard crying and made the sexual allegation known to E6, DSP, who worked 2nd shift on 8/6/11. E6 told R1 she needed to talk to her case manager on Monday.

On 8/18/11 at 3:15pm E3, DSP, stated she became aware of the sexual allegation on 8/7/11 when R1 called her at home after she had seen her sister at church. During their phone conversation R1 began telling E3 the sexual allegations involving E5. E3 told R1 she was not the person to talk to and she needed to talk to E1, QSP, on Monday. When asked why she did not report the allegation immediately E3 stated because she did not believe R1.

E1 in her interview on 8/18/11 stated both E3 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 9	W 149		

E7 stated they should have called (reported the allegation).

2) The facility policy on Abuse and Neglect dated 1/31/08 under PROCEDURES C. General Procedures, "Any employee accused of abuse or neglect will be immediately suspended with pay until completion of the investigation."

The policy does not address the issue of contact between a suspended employee and residents nor does it address staff actions if a suspended employee is on facility grounds.

On 8/31/11 at 10:45am E7, Administrator, informed surveyor E5, Direct Service Person (DSP), had been terminated. E 7 stated E5, an employee who was on suspension for alleged sexual abuse had been on facility grounds, drove the facility bus with R1, R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16 and E9, DSP, to church, was in the church with the residents and drove the bus back to the facility before leaving facility grounds. E7 was asked if E5 had been told he is not to have contact with the residents. E7 stated in E5's first suspension on 8/911 he was told not to come back but on the second suspension on 8/12/11 pending the results of an independent investigation he told him he is off the schedule. E7 stated he didn't specifically tell him he is not to have contact with the residents. E7 was asked if the facility policy on Abuse and Neglect defines a suspended employee's contact with the residents. He stated, "No, it is not that specific." E7 was asked if staff have received training on what to do if a suspended employee comes on facility grounds. E7 stated the 2 staff involved, E4 and E9, he

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W 149	Continued From page 10	W 149		

believes received training from E2, Executive Director. Regarding the facility's other staff, E7 stated he discussed in general terms the nature of E5's termination in violating the terms of the suspension but he did not discuss the issue of suspended employee contact with residents or what staff are to do if a suspended employee comes on facility grounds.

On 9/1/11 at 8:20am E9, Direct Service Person, who accompanied E5 to church with the residents was interviewed. E9 stated E5 called Sunday (8/21/11) morning. "I told him I was going to church. He volunteered to drive. I said yes since I don't know how to drive the bus. E5 arrived at the facility and stayed on the porch. He did not go into the facility. I rounded up all the residents and we went to church. I was not aware he was suspended. We did not know he was not supposed to have any encounter with the residents. I asked him, are you sure you can be here and he told me he wasn't told he could not have any encounter with the residents." E7 stated E2, Executive Director, called her and said, "I know I didn't tell you but if an an employee is suspended they are not to have any contact with residents."

On 9/1/11 at 8:56am the other employee who was present when E5 was on facility grounds, E4, DSP, was interviewed. E4 stated E9 had told her she wanted E5 to drive the bus to church. She said she did not go to church but stayed home with a resident who was having a behavior. She said when E5 first arrived both her and E9 with R3 and R13 were on the porch. E5 she said spoke to R3. E4 stated she knew he was suspended but was not aware he was not to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 11	W 149		

any contact with the residents. "Had I known he couldn't be on premises I would have asked him to leave."

E7, Administrator, was notified the Immediate Jeopardy was removed on 9/6/11at 2:37pm.when the surveyor confirmed through review of the facility plan the facility took the following actions to remove the Immediate Jeopardy.

1) The facility's Abuse and Neglect Policy has been revised to reflect expectations for a staff person who is suspended because of an allegation of abuse or neglect. The following has been added to the policy: "The suspended employee shall not have contact with any person served. The suspended employee shall not be allowed on the ground or inside any agency facility. The suspended employee shall only return to the facility if they are cleared of the allegation and contacted by the administrator that they should return to their schedule duties. This revision is effective 9/1/11. The facility administrator will, in conjunction with the agency administrative team, continue to monitor all agency policies.

2) The facility's Abuse and Neglect Policy has been revised to reflect expectations/duties for on duty staff should another staff member, who has been suspended because of an allegation of abuse or neglect, appear at the facility. The following has been added to the policy: "In the event that a suspended employee comes to the facility, staff on duty shall immediately ask him/her to leave and contact on-call personnel, the Program Administrator or Executive Director to report the incident and receive instructions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 12 The police shall also be called if necessary. This revision is effective 9/1/11. The facility administrator will, in conjunction with the agency administrative team, continue to monitor all agency policies. 3) The 2 staff on duty involved in this incident were immediately re-trained by the Executive Director on 8/22/11 regarding the proper procedures to follow in such an event. 4) Facility staff have been re-trained regarding the policy revisions. Staff received a memo on 8/31/11 detailing the upcoming revisions. The facility administrator was responsible for the memo and will maintain responsibility for monitoring the issue from this point forward. 5) On 9/1/11 staff received copies of the facilities newly revised Abuse and Neglect Policy. Staff have been instructed to review the new policy and initial the procedure review form to indicate that they have received and understand the policy. A member of the agency's administrative team or agency Training Coordinator shall meet on an individual basis with each facility employee for the purpose of reviewing the Abuse and Neglect Policy and ensuring that the employee understands the correct implementation of the procedures of that policy. This will be completed by 9/15/11. While the Immediate Jeopardy was removed on 9/6/11at 2:37pmthe facility remains out of compliance as the facility has not had the opportunity to fully implement the effectiveness of their plan.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF	W 154		9/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIBSTRA HOUSE	**271 EAST 161ST STREET SOUTH HOLLAND, IL 60473**

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W 154	Continued From page 13 CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete a thorough investigation into an allegation of sexual abuse for 1 of 1 clients, R1, who alleged facility staff had touched her inappropriately. Findings include: R1, per the Physician's Orders Sheet dated 7/28/11, is a 57 year old female whose diagnoses include Mild Mental Retardation and Down Syndrome. Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported E5, Direct Service Person (DSP) had touched her private areas on 8/6/11. On 8/18/11 E1, Qualified Service Professional (QSP) at 12:24 pm was asked about the allegation of sexual abuse made by R1. E1 stated R1 told her E5 touched her breasts and vaginal area in the medication room on Saturday (8/6/11) morning and took naked pictures of her with his cell phone in her bedroom at 11:15am. E1 said E5 was suspended on 8/8/11 but had worked on Saturday and Sunday, 8/6/11, 8/7/11, from 7:00am thru 3:00pm. E1 stated the investigation included R1 at 3:30pm on 8/6/11	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

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TIBSTRA HOUSE	271 EAST 161ST STREET SOUTH HOLLAND, IL 60473

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W 154	Continued From page 14 was heard crying and made the sexual allegation known to E6, DSP, who worked 2nd shift on 8/6/11. E6 told R1 she needed to talk to her case manager on Monday. On 8/18/11 at 3:15pm E3, DSP, stated she became aware of the sexual allegation on 8/7/11 when R1 called her at home after she had seen her sister at church. During their phone conversation R1 began telling E3 the sexual allegations involving E5. E3 told R1 she was not the person to talk to and she needed to talk to E1, QSP, on Monday. When asked why she did not report the allegation immediately E3 stated because she did not believe R1. Review of the facility's investigation faxed to the Illinois Department of Public Health dated 8/10/11 includes interviews with R1, R2, Residents, E4, E5, Direct Service Persons, and E1, Qualified Service Professional. The facility's investigation does not include interviews/statements with E3 or E6, the 2 individuals R1 initially told about the sexual allegation. On 8/19/11 at 2:25pm E2, Executive Director, was asked why the facility's investigation did not include interviews/statements by E3 and E6. E2 stated E7, Administrator, did interview them but as to why it was not part of the written investigation stated they focused on getting the information on the allegation into the department.	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress.	W 155		9/20/11

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W 155	Continued From page 15	W 155		

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to prevent potential further abuse of 1 of 1 client, R1, who alleged sexual abuse by a facility staff person. The facility staff were not retrained on reporting an allegation of sexual abuse 2) the alleged perpetrator continued to work after the allegation was made known and prior to the completion of the investigation.

Findings include:

R1, per the Physician's Orders Sheet dated 7/28/11, is a 57 year old female whose diagnoses include Mild Mental Retardation and Down Syndrome.

Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported E5, Direct Service Person (DSP) had touched her private areas on 8/6/11.

On 8/18/11 E1, Qualified Service Professional, (QSP) at 12:24 pm was asked about the allegation of sexual abuse made by R1. E1 stated R1 told her E5 touched her breasts and vaginal area in the medication room on Saturday (8/6/11) morning and took naked pictures of her with his cell phone in her bedroom at 11:15am. E1 said E5 was suspended on 8/8/11 but had worked on Saturday and Sunday, 8/6/11, 8/7/11, from 7:00am thru 3:00pm. E1 stated the investigation stated R1 at 3:30pm on 8/6/11 was heard crying and made the sexual allegation known to E6, DSP, who worked 2nd shift on

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W 155	Continued From page 16 8/6/11. E6 told R1 she needed to talk to her case manager on Monday. On 8/18/11 at 3:15pm E3, DSP, stated she became aware of the sexual allegation on 8/7/11 when R1 called her at home telling her she had seen her sister at church. During their phone conversation R1 began telling E3 the sexual allegations involving E5. E3 told R1 she was not the person to talk to and she needed to talk to E1, QSP, on Monday. When asked why she did not report the allegation immediately E3 stated because she did not believe R1. E2, Executive Director, stated in interview on 8/18/11 at 12:24pm E3 and E6 have been re-inserviced on reporting of abuse/neglect. The other DSP's, E8, E9, E10, E11, E12, E13, E14 and E15 have not been re-inserviced but re-training for all staff is planned.	W 155		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 individuals, R1, who alleged facility staff had touched her sexually is evaluated by medical personnel. Findings include: R1, per the Physician's Orders Sheet dated 7/28/11, is a 57 year old female whose diagnoses include Mild Mental Retardation and Down	W 331		9/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

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W 331	Continued From page 17 Syndrome. The facility policy titled Abuse and Neglect dated 1/31/08 defines Sexual Abuse as, "Any act of sexual contact, sexual penetration, sexual coercion, or sexual exploitation of an individual. Sexual abuse includes, but is not limited to: fondling, body exposure, rape, engagement in sexual acts with the persons served, sexual harassment, etc." The General Procedure section states, "Obtain copies of documents or records that pertain to the incident, including written statements, medical reports, individual records, photographs, and any applicable evidence." Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported E5, Direct Service Person (DSP) had touched her private areas on 8/6/11 including her breasts and vaginal area. Record review of R1's file does not contain any information R1 had been seen medically after the allegation became known. Interview with E1, Qualified Service Professional, on 8/19/11 at 10:45am when asked if R1 had been seen medically stated, "I don't believe so."	W 331		
W9999	FINAL OBSERVATIONS LICENSURE FINDINGS 350.620a) 350.1220e) 350.1220j) 350.3240a) 350.3240b)	W9999		

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W9999	Continued From page 18	W9999		

350.3240e)

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.

Section 350.1220 Physician Services

e) All residents shall be seen by their physician as often as necessary to assure adequate health care.

j) The facility shall notify the resident's physician of any accident, injury, or 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 350.3240 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)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

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W9999	Continued From page 19	W9999		

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These Regulations were not met as evidenced by:

Based on record review and interview, the facility's governing body failed to provide adequate direction for staff to promote the safety for 1 of 1 clients, R1, who alleged a staff person had sexual contact with the client. The facility failed to ensure:
1. Direct care staff immediately reported the allegation of sexual contact to the Administrator
2. The alleged perpetrator did not have contact with this client or others during the course of the investigation
3. Medical personnel assessed R1 for evidence of sexual contact
4. The facility policy for abuse and neglect includes any medical evaluation or the protection of clients related to contact with the alleged perpetrator.

Findings include:

R1, per the Physician's Orders Sheet dated 7/28/11, is a 57 year old female whose diagnoses include Mild Mental Retardation and Down Syndrome.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G238	A. BUILDING ____ B. WING ____	C 09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 20 1) The facility policy titled Abuse and Neglect dated 1/31/08 defines Sexual Abuse as, "Any act of sexual contact, sexual penetration, sexual coercion, or sexual exploitation of an individual. Sexual abuse includes, but is not limited to: fondling, body exposure, rape, engagement in sexual acts with the persons served, sexual harassment, etc." The Procedure section states, "If an employee observes, is told of, or has reason to believe an instance of abuse or neglect has occurred he/she is required to immediately report the allegation to the Program Administrator or designee, who shall then ensure the safety of the persons served and facilitate the removal of potential threat or harm: including removal of accused employee if appropriate." Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported E5, Direct Service Person (DSP) had touched her private areas on 8/6/11. On 8/18/11 E1, Qualified Service Professional (QSP) at 12:24 pm was asked about the allegation of sexual abuse made by R1. E1 stated R1 told her E5 touched her breasts and vaginal area in the medication room on Saturday (8/6/11) morning and took naked pictures of her with his cell phone in her bedroom at 11:15am. E1 said E5 was suspended on 8/8/11 but had worked on Sunday, 8/7/11, from 7:00am thru 3:00pm. E1 stated the investigation stated R1 at 3:30pm on 8/6/11 was heard crying and made the sexual allegation known to E6, DSP, who worked 2nd shift on 8/6/11. E6 told R1 she needed to talk to her case manager on Monday.	W9999		

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W9999	Continued From page 21 On 8/18/11 at 3:15pm E3, DSP, stated she became aware of the sexual allegation on 8/7/11 when R1 called her at home after she had seen her sister at church. During their phone conversation R1 began telling E3 the sexual allegations involving E5. E3 told R1 she was not the person to talk to and she needed to talk to E1, QSP, on Monday. When asked why she did not report the allegation immediately E3 stated because she did not believe R1. E1 in her interview on 8/18/11 stated both E3 and E7 stated they should have called (reported the allegation). 2) The facility policy on Abuse and Neglect dated 1/31/08 under PROCEDURES C. General Procedures, "Any employee accused of abuse or neglect will be immediately suspended with pay until completion of the investigation." The policy does not address the issue of contact between a suspended employee and residents nor does it address staff actions if a suspended employee is on facility grounds. On 8/31/11 at 10:45am E7, Administrator, informed surveyor E5, DSP, had been terminated. E 7 stated E5, an employee who was on suspension for alleged sexual abuse had been on facility grounds, drove the facility bus with R1, R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16 and E9, DSP, to church, was in the church with the residents and drove the bus back to the facility before leaving facility grounds. E7 was asked whether E5 had been told he is not to have contact with the residents. E7 stated in	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 22 E5's first suspension on 8/911 he was told not to come back but on the second suspension on 8/12/11 pending the results of an independent investigation he told him he is off the schedule. E7 stated he did not specifically tell E5 he is not to have contact with the residents. E7 was asked whether the facility policy on Abuse and Neglect defines a suspended employee's contact with the residents. He stated, "No, it is not that specific." E7 was asked whether staff have received training on what to do if a suspended employee comes on facility grounds. E7 stated the two staff involved, E4 and E9, he believes received training from E2, Executive Director. Regarding the facility's other staff, E7 stated he discussed in general terms the nature of E5's termination in violating the terms of the suspension but he did not discuss the issue of suspended employee contact with residents or what staff are to do if a suspended employee comes on facility grounds. On 9/1/11 at 8:20am, E9, DSP, who accompanied E5 to church with the residents was interviewed. E9 stated E5 called Sunday (8/21/11) morning. "I told him I was going to church. He volunteered to drive. I said yes since I don't know how to drive the bus. E5 arrived at the facility and stayed on the porch. He did not go into the facility. I rounded up all the residents and we went to church. I was not aware he was suspended. We did not know he was not supposed to have any encounter with the residents. I asked him, are you sure you can be here and he told me he wasn't told he could not have any encounter with the residents." E7 stated E2, Executive Director, called her and said, 'I know I didn't tell you but if an an employee is suspended they are not to have any contact with	W9999		

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	14G238	A. BUILDING ______ B. WING ______	C 09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIBSTRA HOUSE	271 EAST 161ST STREET SOUTH HOLLAND, IL 60473

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W9999	Continued From page 23 residents.'" On 9/1/11 at 8:56am the other employee who was present when E5 was on facility grounds, E4, DSP, was interviewed. E4 stated E9 had told her she wanted E5 to drive the bus to church. She said she did not go to church but stayed home with a resident who was having a behavior. She said when E5 first arrived both her and E9 with R3 and R13 were on the porch. E5 she said spoke to R3. E4 stated she knew he was suspended but was not aware he was not to have any contact with the residents. "Had I known he couldn't be on premises I would have asked him to leave." 3) The facility policy titled Abuse and Neglect dated 1/31/08 defines Sexual Abuse as, "Any act of sexual contact, sexual penetration, sexual coercion, or sexual exploitation of an individual. Sexual abuse includes, but is not limited to: fondling, body exposure, rape, engagement in sexual acts with the persons served, sexual harassment, etc." The General Procedure section states, "Obtain copies of documents or records that pertain to the incident, including written statements, medical reports, individual records, photographs, and any applicable evidence." The policy does not define what specific medical action is to be taken when an allegation of sexual abuse occurs. Review of an Allegation of Abuse/Neglect Report dated 8/8/11 completed by E7, Administrator, notes R1 after returning from work on 8/8/11 reported E5, Direct Service Person (DSP) had touched her private areas on 8/6/11 including her	W9999		

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W9999	Continued From page 24 breasts and vaginal area. Record review of R1's file does not contain any information R1 had been evaluated by a medical person (nurse or physician). Interview with E1, Qualified Service Professional, on 8/19/11 at 10:45am when asked whether R1 had been seen medically stated, "I don't believe so." Interview with E2, Executive Director, on 8/19/11 at 2:25pm acknowledged the facility policy on abuse/neglect does not address specifically what medically action is to be taken in the event of a sexual allegation.	W9999		