STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. BUILDING _____ B. WING _____	C 03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA REG REHAB CENTER	**302 WEST BURWASH SAVOY, IL 61874**

(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 282	Continued From page 18 discharge from the Facility (R4) in the sample of 10. Findings include: R4's Physician Order Sheet dated 11/01/11 to 11/30/11 documents the following diagnoses for R4: Aftercare for Knee Replacement, Osteoarthritis, Diabetes Mellitus, and Atrial Fibrillation. A Physician's Telephone Order dated 11/15/11 directs staff to "Send all medications home with (R4)--home on same routine medications." Nurse's Notes written by E13, Licensed Practical Nurse (LPN) dated 11/16/11 do not document that medications were sent home with R4. On 03/16/12 at 2:55pm E13 stated that if her Nurse's Note did not say she sent the medications home, then she did not. On 03/16/12 at 3:15pm, E3, Registered Nurse (RN) and Nursing Supervisor confirmed that R4's insurance would have allowed R4 to take the medications home. On 03/16/12 at 3:15pm, E3 also confirmed that R4's medications were not sent home with her upon discharge. On 03/15/12 at 11:53am, Z1, Responsible Party, confirmed that R4's medications were not sent home with her upon discharge.	F 282		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 19 LICENSURE VIOLATIONS 300.1210b) 300.3240a) 300.3240b) 300.3240d) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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. Section 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) 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. 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. f) Resident as perpetrator of abuse. When an	F9999		

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F9999	Continued From page 20	F9999		

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 and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

These Regulations are not met as evidenced by the following:

Based on observation, interview and record review, the facility failed to identify inappropriate touching by R10 toward an unidentified resident and R8 as sexual abuse. This failure resulted in repeated resident to resident sexual abuse by R10. R8 is for one of four residents (R8) reviewed for abuse in the sample of ten. This failure allowed the alleged perpetrator to have continued access to R8 and other female residents.

Findings include:

R8's Physician's Order Sheet (POS) dated 03/01/12 to 03/31/12 documents the following diagnoses: Dementia and Multiple Sclerosis.

R8's Minimum Data Set (MDS) dated 02/29/12 indicates that she is moderately cognitively impaired.

R10's POS dated 03/01/12 to 03/31/12 documents the following diagnoses: Dementia and Depression.

R10's MDS dated 01/31/12 indicates that he is

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F9999	Continued From page 21 moderately cognitively impaired. On 03/23/12 at 1:00pm, R8 stated that R10 came into her room and put his hand under her blanket and clothing and ran his finger up the front of her lower leg, over her knee, and touched her lower thigh (just above her knee). R8 stated she was seated in her chair in her room. R8 also demonstrated R10's touch by touching her lower leg and bringing her fingers up her lower leg, over the knee, and slightly above her knee. R8 stated again that he touched her bare skin, and indicated that she perceived this to be sexual in nature. R8 stated that she then began yelling for him to stop and get out of her room. R8 stated he stopped and left her room. R8 stated that she does not remember the date of this incident. The Occurrence Report dated 03/10/12 indicates that the incident occurred on 03/10/12; the time on the Occurrence Report was 1:05pm. On 03/23/12 at 1:00pm, R8 stated that R10 returned to R8's room and confronted her, stating that he used to think she was a nice lady, but that he didn't think so anymore. R8 told R10 to leave her room and he left. R8 was unable to recall the date that R10 returned to her room. R8 also stated that some time after this incident R10 was moved downstairs (the first floor). A Social Service Progress Note dated 03/13/12 written by E5, Licensed Social Worker (LSW), reports that R8 told E5 that R10 "has been coming to her room to visit and last week he came into her room and ran his finger up the side of her leg." After yelling at R10 to get out of her room, "he laughed at her and thought it was	F9999		

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funny." On 03/12/12, R10 "came back to her room and told her he was mad at her and that it was her fault that he was being moved downstairs." E5 also documented at that time that R8 stated "no one has the right to do that to me and I do not feel safe with him around." E5 did not report the allegation to E6, previous Administrator.

According to a statement written 03/13/12 (no time recorded), E12, Certified Nursing Assistant (CNA), reported to the North Hall nurse that R8 told her about the inappropriate touching by R10 on 03/10/12 (Saturday).

On 03/23/12 at 4:33pm, E4, Licensed Practical Nurse (LPN) stated that a CNA reported to her the allegation by R8 on 03/10/12. E4 stated that she talked to R8 and R10. E4 stated that R8 was very upset by the inappropriate touching. E4 stated that R10 said little and seemed to not remember the incident. E4 stated that R8 and R10 were separated, and that she directed the other nurses and CNAs working that evening to keep R8 and R10 separated and to watch both of them. E4 stated that all staff knew to keep R8 and R10 separated and watch them 03/10/12 (Saturday) and 03/11/12 (Sunday). E4 stated that neither resident was sent out for evaluation and neither resident was assigned one to one observations on 03/10/12 or 03/11/12.

The In-House Transfer Sheet dated 03/12/12 indicates that R10 was moved from the second floor (where R8 lives) to the first floor on 03/12/12, two days after he inappropriately touched R8.

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E4 stated that she reported the allegation to E3, Registered Nurse (RN) and Nursing Supervisor, on 03/10/12 but does not remember the time she notified her.

On 03/23/12 at 4:33pm E4 confirmed that she did not notify the Administrator.

A document written 03/12/12 at 4:59pm by E2, Director of Nursing (DON), reports that E2 spoke with E4 regarding her direction to the staff working 03/10/12 and 03/11/12. E2 reports that E4 stated, "She (E4) notified (R10's) nurse and other CNAs to keep an eye out on (R10) due to the fact that R8 did not want him in her room." E2 and E4 failed to identify this incident as sexual abuse.

The 24 Hour Report dated 03/10/12 directs staff to "notify staff of incident with (R10). Separate the two (R10 and R8)."

The 24 Hour Report dated 03/11/12 directs staff to "Notify staff of incident with (R10)."

A Social Service Progress note dated 10/20/11 written by E7, Licensed Social Worker (LSW) also indicates R10 was involved in another incident of inappropriate, sexual touching which occurred on 10/19/11 with an unidentified resident. The Progress note dated 10/20/11 documents "(R10) was witnessed by nurse on 10/19/11 evening touching other resident between legs. SW (Social Worker) asked if he remembered doing that. (R10) replied yes."

On 03/28/12 at 8:35am E7, LSW, stated that she was asked by a nurse (E7 could not remember

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F9999	Continued From page 24 her name) to talk to R10 on 10/20/11 because of the incident of inappropriate touching. E7 stated that she did not report the allegation to E6, Previous Administrator, because she thought it had been reported the day it occurred. Nurse's Notes dated 10/20/11 indicate that R10 was "on 15 minute observational checks today." There is no documentation of 15 minute checks beyond 10/20/11. No other interventions for R10 were implemented. R10 was not removed from resident contact. R10 was allowed unrestricted access to the alleged victim and other female residents. (A)	F9999		