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F 441	Continued From page 35 The findings include: 1. The facility infection control information was reviewed on 3-13-13. There was no information pertaining to employee infections and illnesses in this infection control information. On 03-14-13 at 2:50 pm, E1, Administrator, verified that they do not track employee symptoms to determine trends and monitor infections staff are experiencing. The facility's Resident Census and Conditions of Residents form completed by E1, Administrator, on 03-12-13, documented the facility had a census of 29 residents. 2. Observation of the noon time medication administration (11:00 A.M. - 12:30 P.M.) on 3/18/2013 with E10/LPN noted several instances of failure to wash/sanitize hands as appropriate when providing care/services. It was noted that E10 did not wash/sanitize her hands between changing gloves after doing accucheck and giving insulin injection, and before and after giving oral medication to R6. E10 did not wash/sanitize her hands after removing gloves when she wiped off the glucometer machine after doing accucheck on R1. E10 failed to wash/sanitize her hands after doing accucheck and before giving insulin injection in the dining room to R3. E10 did not wash/sanitize her hands after removing gloves after doing accucheck and before and after giving insulin injection in the dining room to R8.	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations:	F9999		

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300.610a)
300.690a)
300.690b)
300.690c)
300.695b)3)
300.695c)1)5)
300.695d)
300.695e)
300.1210b)
300.3240a)
300.3240c)
300.3240d)
300.3240e)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all

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F9999	Continued From page 37 written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.695 Contacting Local Law Enforcement	F9999		

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F9999	Continued From page 38 b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 5) Facility investigation of the situation. d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c). e) The facility shall also comply with other reporting requirements of this Part. 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	F9999		

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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)

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)

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)

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)

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F9999	Continued From page 40 These Regulations were not met as evidenced by: Based on interview, observations, and record review, the facility failed to thoroughly investigate an allegation of sexual abuse, protect residents during the investigation, and failed to ensure that all allegations of sexual abuse are immediately reported to the local law enforcement and the state agency, and the facility failed to develop and implement an abuse prohibition policy that complied with federal regulations by requiring the immediate reporting to the state agency of all allegations of abuse, neglect, mistreatment, or misappropriation of resident property and failed to implement its abuse prohibition policy to ensure that all allegations of sexual abuse were reported immediately to the state agency and the police. In addition, the facility failed to ensure that residents were protected during the investigation from a Licensed Practical Nurse and a resident of the facility, accused of sexual abuse. On 03-08-13, facility staff had knowledge of an allegation of sexual abuse which would require the facility to initiate the facility policy and procedures for alleged sexual abuse, immediately report to the state agency and the police, and would require the facility to protect all residents during the investigation from the accused staff, E8, and the accused resident, R2. These failures resulted in all 29 residents in the facility being put at risk of potential abuse due to the failure to protect residents from the accused staff (E8) and the accused resident (R2), while	F9999		

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the investigation is conducted, thoroughly investigate, and report a suspicion of sexual abuse to the local law enforcement and the state agency as required.

The findings include:

Review of the facility policy titled "Abuse Prevention Program - Facility Policy and Procedure" with a revision date of 01-16-11 documents under the heading Protection of Residents, "Residents who alleged allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation." and "Employees of this facility who have been accused or suspected of resident abuse, neglect or misappropriation of property will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator."

The facility policy titled "Abuse Prevention Program - Facility Policy and Procedure" with a revision date of 01-16-11 documents under the heading Internal Reporting Requirements and Identification of Allegations section "Upon learning of any report of suspected mistreatment, the administrator shall initiate an investigation. If the administrator has determined that there is reasonable cause to suspect that mistreatment may have occurred, the resident's representative, physician, and the Illinois Department of Public Health will be notified immediately."

1. A written notification by E1, Administrator,of an

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allegation of abuse was faxed to the state agency regional office on 03-09-2013 at 1:49 pm according to the date and time printed on this notification by the fax machine. The notification documents that on the afternoon of 03-08-13, Z2, Registered Nurse from a local hospital, called E1 and reported that R10 (a resident from the facility) had been admitted to the hospital. Z2 said that R10 told them that E8, Licensed Practical Nurse, and R2 were having sex with four of the facility residents in the facility. In this notification E1 stated that he interviewed E8 and found no knowledge of the accusations and that R2 is in a wheel chair and paralyzed on his left side. The last paragraph of this notification documents, "As for the accusations by R10, I have found no evidence that implicated anyone except R10's behavior toward these women."

On 03-13-13 at 11:00 am, E1, Administrator was interviewed and stated that Z2 called the facility and spoke with E1 at 3:30 - 3:40 pm on 03-08-13 about allegations of sexual abuse by E8, Licensed Practical Nurse and R2 against R6, R7, R8 and R9. E1 said that he immediately started the investigation and interviewed E8 who was on duty. E1 stated during this interview that he did not remove E8 from resident contact or send E8 home because he was passing medications and there was not another nurse in the facility at that time.He then interviewed residents and any staff that were there at the time about any knowledge of the allegations. E1 stated that he came back into the facility on 03-09-13 to complete the investigation and send a letter to the Illinois Department of Public Health - Long Term Care. E1 stated on 03-14-13 at 10 am that he did not immediately contact the state agency and did not

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contact the local police. E1 also stated during this 03-14-13 at 10 am interview that he came to the conclusion there was no concern with E8 or R2 on 03-09-13.

A report of the allegation of sexual abuse was received by the state agency's regional office by fax from the facility on 03-09-2013 at 1:49 pm as noted by the date and time on the report.

On 03-13-13 at 11:00 am, E1, Administrator was interviewed and stated that Z2 called the facility and spoke with E1 at 3:30 - 3:40 pm on 03-08-13 about allegations of sexual abuse by E8, Licensed Practical Nurse and R2 against R6, R7, R8 and R9. E1 said that he immediately started the investigation and interviewed E8 who was on duty. E1 stated that he did not remove E8 from resident contact or send E8 home because he was passing medications and there was not another nurse in the facility at that time. He then interviewed residents and any staff that were there at the time about any knowledge of the allegations. E1 stated that he came back into the facility on 03-09-13 to complete the investigation and to send a letter to the Illinois Department of Public Health - Long Term Care. E1 stated on 03-14-13 at 10 am that he did not immediately contact the state agency and did not contact the local police. Also, E1 stated during this 03-14-13 at 10 am interview that he came to the conclusion there was no concern with E8 or R2 on 03-09-13.

E1 was interviewed again on 03-13-13 at 1:30 pm and stated that they did not put any monitoring in place for R2 on 03-08-13 when R2 was accused of sexual abuse. E1 stated on 03-14-13 at 9 am

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that R2 has been removed from the other residents to his room since 5 pm on 03-13-13 and was put on 15 minute checks pending the completion of the investigations. This was verified by observations on 03-14-13 at 10 am.

E8 was interviewed on 03-13-13 at 2:15 pm and stated that E1 called E8 into his office and told him of the allegations. E8 stated he told E1 he did not do anything inappropriately. E8 stated that after the conversation E1 was going to interview the staff on duty. Also, E8 stated that he interviewed R6, R7, R13, and R14. E8 also stated during this 03-13-13 interview that he worked his 2 pm to 10 pm shift on 03-08-13, 03-09-13, and 03-10-13, was off on 03-11-13 and 03-12-13 and returned to work on 03-13-13.

Review of the time card for E8 documents that E8 worked his 2 pm to 10 pm shift on 03-08-13 (the day the complaint was called in at 2:20 pm to E1) through 03-10-13, was off the next two days, and returned to work on 03-13-13 but only worked from 2:51 pm to 5:21 pm. when E8 was sent home until the investigation was completed.

The three interviews dated 03-09-13 (with no time given) conducted by E8 as part of the sexual abuse investigation were reviewed. These interviews were with R6, R7 and R13. R6, R7 and R13 stated that R10 had grabbed their breasts. R13 stated to E8 that she was afraid to tell anyone about it because of what R10 might do.

E5, Social Service Designee, was interviewed on 03-12-13 at 2:25 pm, and stated that she received notes about R10 on 03-11-13 when she

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returned to work, that is when she first became aware of any allegations . R7 told E5 that R10 had touched R7's breast and two weeks prior rubbed his hand between R7's legs and R10 had also asked R7 to go to bed with him. R7 told E5 that she had not told anyone of these incidents.

R7 was interviewed on 03-14-13 at 2:05 pm and stated that she had never had any problems from staff but she had a resident, R10, who was always trying to grab her breast or between her legs. R7 stated that she did not tell anyone.

Also, E5 stated on 03-12-13 at 2:25 pm that R2 makes comments at times but E5 has not had any reports of R2 touching any of the residents. E5 stated there had been some reports of R2 inappropriately touching Certified Nurses Assistants during transfer and that R2 was grabby with their rear ends.

On 03-12-13 at 9:20 am, E3, Care Plan Coordinator, stated that R2 was interviewable. Review of R2's medical record documents that staff have been tracking behaviors of sexual comments towards others and inappropriate touching of self/others. The November, 2012 through February, 2013 Care Plan/Behavior Tracking Record was reviewed and found that behaviors were occurring at least monthly. This record also documents that R2 was making sexual comments to staff only. This record also documents that R2 was making sexual comments to staff only.

R10's Minimum Data Set dated 02-01-13 documents that R10 was interviewable. The Care Plan for R10 dated 11-06-12 documents a

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problem of making inappropriate comments to the staff. The facility Care Plan/Behavior Tracking Record for R10 documents a problem of making sexual comments toward staff. These records indicate no behaviors in December, 2012 and January, 2013. There were 3 entries of this behavior in February, 2013.

A written notification of the conclusion of the allegation of sexual abuse was faxed to the state agency regional office on 03-14-13 at 5:03 pm. This notification documents that on 03-09-13 "the facility was made aware of the allegations that R10 had grabbed 5 women's breast and rubbed between one female resident's legs. The women were interviewed by two different staff members and were consistent each time. Four of the five women said that R10 touched them inappropriately and that they had not reported it because they were afraid of what R10 would do. The fifth resident could recall no such incident, however this resident has a diagnosis of Dementia." This notication documents that law enforcement was notified on 3-14-13. This written notification also documents that R10 has been in the hospital since 03-07-13, does not want to return to the facility, and family removed his personal effects from the facility on 03-12-13.

E1 stated on 03-14-13 at 9 am that he did not notify the regional office immediately because he was busy with the investigation and thought he had 24 hours to notify the department. Also, E1 stated that he did not notify the police because he did not find the allegations to be true and did not feel he needed to notify the police.

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F9999	Continued From page 47 2. The facility's Abuse Prevention Policy was reviewed on 03-13-13. This policy does not address Section 1150 B of the Social Security Act that became effective on 03-23-11. Section 1150 B establishes two time limits for the reporting of reasonable suspicion of a crime. Also, there should have been a sign posted indicating the required posting of information concerning staff reporting. There was no sign observed during this survey. E1 stated he was not aware of this new information concerning reporting of a crime or the need to post required information. The facility's Resident Census and Conditions of Residents form completed by E1, Administrator, on 03-12-13, documented the facility had a census of 29 residents. (A)	F9999		