STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING _____ B. WING _____	C 12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

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F 000	INITIAL COMMENTS Complaint Investigation 1475625/IL73741 - F225, F226	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify local law enforcement during an allegation of sexual abuse of two residents. The facility also failed to include one of two residents in the report to the state agency, Illinois Department of Public Health. This applies to 2 of 4 residents (R2 and R3) reviewed for abuse. The findings include: On 12/15/2014 at 12:05pm, E2 (Director of Nursing/DON) said that on 12/12/2014 at approximately 12:30pm she was notified by E6 (Physical Therapist) and E7 (Restorative Aide) of an incident involving R1. Both E6 and E7 reported to her that R1 told them he had a "Boobie Call" the previous night in which R1 had fondled the breasts of R2 and R3. E2 said that she interviewed R1 at that time and he denied that the incident happened and he was only bragging. E2 stated that she started monitoring the whereabouts of R1, R2 and R3 every 15 minutes at 1:00pm. E2 said that she contacted E1 (Administrator) at approximately 2:30pm who had told her to continue to watch R1 every 15 minutes and send him to the hospital. E2 stated that this was not reported to Illinois Department of Public Health (IDPH) or the police at that time. E2 said that R1 is alert and oriented to person and place but he has dementia. She said that R1 can transfer himself from a bed to a wheelchair and	F 225		

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F 225	Continued From page 2 he is able to propel himself in the wheelchair. On 12/15/2014 at 1:06pm, E4 (Social Worker/Director of Social Services) stated that Z1 informed her of the incident involving R1 when she came to work on 12/13/2014. E4 said she spoke with E2 on 12/13/2014 at approximately 9:00 or 9:30am. She said she was told by E2 that the incident was not reported to IDPH on Friday because R1 had denied that anything had happened and he had made it up to make the staff jealous. E4 said that she told E2 that it should be reported to IDPH. E4 said she then submitted the incident which included R1 and R2 to IDPH. E4 said that any allegation of abuse should be reported to the DON as the abuse coordinator and to the administrator immediately. She said the police should also be notified within two hours of an allegation. E4 said that the police were notified on 12/15/2014. On 12/16/2014 at 10:28am, E4 stated since R1 had denied fondling anyone's breasts and nobody could verify the incidence, the police were not called on Saturday. E4 said she was not aware that R3 was involved in the incident until 12/15/2016, so R3 was not mentioned in the initial report sent to IDPH on 12/13/2014. E4 said that R3 should have been included in the initial report on 12/13/2014. On 12/17/2014 at 10:25am, Z1 (IDPH monitor) stated that on 12/13/2014 at approximately 8:30 or 9:00am he had interviewed R1 regarding the allegations he had made the prior day. Z1 stated that the interview took place with E4 present in her office. Z1 said that E4 had left several times during the course of the interview. During the interview R1 told Z1 he had "two young ladies", R2 and R3, that he was fooling around with. R1 said that he was aware that it was wrong because	F 225		

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F 225	Continued From page 3	F 225		

the women "aren't all there". R1 also said that he should not have been in contact with R3 but he couldn't help himself.

On 12/16/2014 at 9:23am, E6 (Physical Therapist) stated during therapy on 12/12/2014 R1 had told him that he was touching the "boobs" of R2 and R3. He couldn't recall if R1 had mentioned when it took place. E6 said that he had seen R1 together with R3 in the past. He had also seen them holding hands once in awhile in the corridor. E6 said that he reported the incident on 12/12/2014 to E2 immediately.

On 12/15/2014 at 2:12pm, E5 (Certified Nurse Assistant) stated that approximately a month ago R1 had asked her to put cream on his testicles. She said that she asked a coworker about it and she was told that they are just suppose to redirect him and tell him that he could do it himself. E5 stated that he would ask the other certified nursing assistants also to put cream on his testicles. She said that she did not report this to anyone.

On 12/15/2014 at 3:15pm, E1 (Administrator) stated that on 12/12/2014 at approximately 2:30pm he was informed by E2 of an incident in which R1 told E7 he had a "Boobie Call" with another resident the previous night. E1 said that E2 told him that she had interviewed R1 and he denied that the incident happened and that R1 said he was only bragging. E1 stated that he was also told by E2 that the incident reported by E7 was to have occurred in the dining room which was an "open area" which was visible to staff and residents. E1 also stated that nobody had come forth to say they had seen this allegation occur or that the allegation had happened to them. E1 said

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that there was "no credible source" that could verify the incident. E1 said that R1 must have told Z1 a different story on 12/13/2014 that he did fondle R2 and R3's breasts. E1 stated that local law enforcement was not notified because R1 had told the facilities staff that nothing had happened. E1 said that R1's "credibility was in doubt from day 1". According to E1, the police were called on 12/15/2014 because R1 had admitted to E1 that he had touched someone. E1 stated that under normal circumstances when someone reports that abuse happened to them, the facility would notify the doctor, the family, IDPH, and the police. E1 said that in this instance the person self reported to a staff member that he did something to another resident and that staff person reported it immediately to the DON. He said nobody else came forward to tell the staff about this incident and R1 had then denied the incident when the DON spoke with him. E1 said that on Friday 12/12/2014 that this story was not believable. E1 stated that the staff has been trying to find a hospital placement for R1 since Friday and the plan to protect other residents was to place R1 on watch every 15 minutes.

According to the admission face sheet, R1 had diagnoses including Bipolar Disorder and Dementia. The Brief Interview for Mental Status (BIMS) dated 10/17/2014 showed that R1 was cognitively intact. R1 had a Behavior Contract dated 11/18/2014 that showed making inappropriate sexual comments to female staff and female residents, confabulating stories, and asking female staff and or resident's to do inappropriate sexual things would result in involuntary psychiatric hospitalization and 30 day notice of involuntary discharge from facility.

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F 225	Continued From page 5 According to the admission face sheet, R2 had diagnoses including Seizures, Schizophrenia, Moderate Intellectual disabilities, and subacute dyskinesia. The BIMS dated 10/25/2014 showed that R2's cognition was moderately impaired. According to the admission face sheet, R3 had diagnoses including Bipolar Disorder, Anxiety, Depression, and Hallucinations. R3's care plan showed that she had cognitive impairment. The Minimum Data Set dated 11/17/2014 showed that R3's cognition was moderately impaired. The facilities Abuse Prevention Program Policy dated 08/26/2014 showed "If a crime, particularly involving physical or sexual abuse, is suspected, it must be reported to the state survey agency and local law enforcement...not later than 24 hours after forming the suspicion".	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its abuse policy by not contacting resident representatives and local law enforcement to report allegations of sexual abuse. In addition the facility's abuse policy failed to give specific direction to staff on initial reporting of an abuse allegation to the State Survey	F 226		

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F 226	Continued From page 6 Agency. This applies to two (R2, R3) of four residents reviewed for abuse in a sample of four. The findings include: On 12/15/14 at 2:21 PM, E7 (Restorative Aide) stated that on 12/12/14 while he and E6 (Physical Therapist) were walking a facility resident (R1) the resident stated that he had gotten some "action" last night. E7 stated that R1 went on to state that on the previous evening (12/11/14) while in the facility's main dining room he fondled a female resident's (R2) breast. E7 stated that R1 also said that he had fondled a second female's breast (R3) as well, but did not give any details. E7 stated that immediately after completing R1's walk he reported the alleged incident to the facility's Director of Nursing (E2). On 12/15/14 at 12:05 PM, E2 stated that on 12/12/14 at approximately 12:30 PM, E6 and E7 reported to her that R1 had fondled the breast of R2 and R3. E2 stated that she did not immediately report the incident to the Illinois Department of Public Health (IDPH) or local law enforcement because when she talked to R1 he denied that the incident ever happened. E2 stated that R2 also denied that the incident had occurred. E2 stated that she was not able to speak with R3 because R3 was out of the facility with family at the time. When asked if the resident's representatives and physician were notified of the alleged incidents E2 stated that she had instructed the assigned nurse (E3) on duty to contact the physician and family, but wasn't sure if the contacts had been made.	F 226		

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E2 stated that the incident involving E2 was reported to IDPH on 12/13/14 after consulting with the facility's Social Services Director (E4). According to E2 local law enforcement was notified on 12/15/14, three days after the alleged incident was originally reported to the facility.

Review of nursing progress notes (12/12/13, 12/13/14) found in R2 and R3's medical record did not show that the resident's physicians or representatives were notified of the alleged incidents of abuse.

Review of facility abuse records did not show that the incident involving R3 was reported to IDPH. On 12/17/14 at 11:55 AM, E2 stated that the alleged incident involving R3 wasn't reported to IDPH until 12/16/14 because she either forgot to mention the incident on 12/13/14 to E4 or the information was miscommunicated.

On 12/15/14 at 3:15 PM, the facility's administrator (E1) stated that on 12/12/14 at 2:00 PM he was informed by E2 that E7 reported to her that during physical therapy R1 claimed to have fondled R2 and R3 the previous evening. E1 stated that law enforcement wasn't called because R1 initially denied that the incident had happened and at the time there was no credible source to corroborate the alleged incident ever occurred. E1 stated that on 12/15/14 the facility decided to contact law enforcement after R1 admitted during a subsequent interview to touching R2 and R3.

On 12/15/14 at 1:06 PM, E4 described R3 as having major cognitive issues and R2 as having moderate mental retardation. According to R1's most recent minimum data set assessment

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F 226	Continued From page 8 (10/17/14) R1 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) portion of the assessment. According to the facility's Abuse Prevention Program Policy and Procedure (updated 8/26/14) internal reporting: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect to the administrator or the person in charged of the facility acting on behalf of the administrator, or an immediate supervisor who must then immediately report it to the administrator; If a crime, particularly involving physical or sexual abuse, is suspected, it must be reported to the state survey agency and local law enforcement under the following timeframe: - Serious Bodily Injury - immediately but not later than 2 hours after forming the suspicion - All other - not later than 24 hours after forming the suspicion. The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment and that an investigation is being conducted. The policy's section on external reporting conflicts with current regulation and states that if mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed as soon as possible within 24 hours.	F 226		

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F 226	Continued From page 9 No where in the facility's policy is it clear that all allegations or suspicion of potential abuse, neglect or misappropriation of property are to be reported to IDPH.	F 226		