STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145732	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	**509 NORTH ADELAIDE NORMAL, IL 61761**

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F 000	INITIAL COMMENTS Complaint #1663226/IL86178 A partial extended survey was conducted.	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to prevent sexual aggression by one resident (R2) toward another resident (R1). R1 and R2 are two of three residents reviewed for abuse in a sample of three. Findings include: R1's Physician Order Sheet dated June 2016 documents the following diagnoses: Dementia without Behavioral Disturbance, Heart Failure, Essential Hypertension and Anxiety Disorder. The Minimum Data Set for R1 dated 5/19/16 documents R1 with moderately impaired cognition and uses a wheelchair for mobility purposes. R1's Care Plan dated 6/10/16 documents that R1 is totally dependent on staff for all activities of daily living.	F 223		

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

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F 223	Continued From page 1 R2's Physician Order Sheet dated June 2016 documents the following diagnoses: Hepatic Failure, Cirrhosis of Liver, Diabetes Mellitus Type 2 and Hypertension. R2's Minimum Data Set dated 6/2/16 documents R2 as cognitively intact, independent in ambulation and walks with a cane. On 6/16/16 at 5:49PM Z1, R2's Primary Care Physician stated " (R2) is very alert and oriented and understands what he is doing and saying. (R2) is totally aware of what is going on around him." The following eyewitness accounts document separate occurrences of sexual abuse by R2 towards R1: 1. R1's Progress note dated 6/15/16 at 6:37 PM completed by E1, Administrator documents, "Late Entry Incident involving male resident 6/13/16 approximately 7:30 PM. Staff reported male resident 'pinched' resident's breasts. PCP (primary care physician) notified..." The facility's document titled "Report to Illinois Department of Public Health" dated 6/16/16 states " "...On June 13, 2016, staff reported to Administrator male resident (R2) was in lounge area bent over female resident (R1), and 'pinched' her breast...." E3, Certified Nurses Assistant (CNA) documents in writing on 6/13/16 the following: "I was walking into the east lounge area and saw (R2) on the left side of (R1). (R2) was bent over touching (R1's) left breast. I believe (R2) pinched her breast; it was not a grab or groping. I asked (R2) what he was doing; (R2) acted like he was brushing something off of (R1's) shirt in the chest area. I	F 223		

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F 223	Continued From page 2	F 223		

believe he touched her right breast at that time. I explained to him that was inappropriate...."

E3 stated in interview on 6/15/16 at 11:54 AM the following; "I was in the lounge walking I came upon (R2) standing on (R1's) left side (R1) was in her wheelchair, (R2) had his right hand underneath (R1's) left breast . (R2) pinched her breast, (R1) did not say anything. I told (R2) that was inappropriate and (R1) looked at me and stated 'that was inappropriate' and then (R2) was acting like he was brushing crumbs off (R1's) blouse and then (R2) touched (R1's) right breast the same way again in front of me."

The facility's investigation forms given to employees dated 6/14/16 completed by E4, CNA documents "Yes a few times I saw (R2) cupping (R1)'s breast and attempt to kiss (R1). "

2. E4's written documentation dated 6/15/16 states " I came back to work around September/October 2015. I saw (R2) cup (R1's) breast a few months ago."

On 6/16/16 at 8:56 AM E4 stated, "This incident involving (R1 and R2) him cupping her breast which I actually saw happened a few months ago. (R2) was cupping (R1's) breast and attempted to kiss (R1). (R1) did nothing, I moved (R1) to another area and told (R2) to go to his room, which he did do. I told the floor nurse that was available. The nurse stated she would report it. I did not call the Administrator because the floor nurse states she would report it. (R1) is very touchy-feely person and I don't know if (R2) was taking advantage of that. I feel (R2) is coherent enough to know better."

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F 223	Continued From page 3 R2 was seen walking throughout the building on 6/15/16 through 6/16/16 without assistance of staff. R2 was in the dining room, the lounge area on east hall, sitting in the front lounge area in front of the dining room and was also seen walking toward the west area of the building. The facility's policy dated 4/23/14 titled " Policy and Procedure Regarding Abuse and Neglect, Misappropriation of Resident Property and Injuries of Unknown Origin" states "#1. All residents have the right to be free of from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."	F 223		
F 225 SS=F	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).	F 225		

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F 225	Continued From page 4 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 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, observation, and record review the facility failed to immediately report an allegation of sexual abuse to the Administrator and the State agency, failed to remove an alleged perpetrator from further contact with residents and failed to investigate an allegation of sexual abuse for two (R1 and R2) of three residents reviewed for abuse in a sample of three. This failure has the potential to affect all 111 residents residing in the building. Findings include: R1's Physician Order Sheet dated June 2016 documents the following diagnoses: Dementia without Behavioral Disturbance, Heart Failure, Essential Hypertension and Anxiety Disorder. The Minimum Data Set for R1 dated 5/19/16 documents R1 with moderately impaired cognition and uses a wheelchair for mobility purposes. R1's Care Plan dated 6/10/16	F 225		

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F 225	Continued From page 5	F 225		

documents that R1 is totally dependent on staff for all activities of daily living.

R2's Physician Order Sheet dated June 2016 documents the following diagnoses: Hepatic Failure, Cirrhosis of Liver, Diabetes Mellitus Type 2 and Hypertension. R2's Minimum Data Set dated 6/2/16 documents R2 as cognitively intact, independent in ambulation and walks with a cane. R2's Primary Care Physician (PCP)Z1 stated on 6/16/16 at 5:49 PM (R2) is very alert and oriented and understands what he is doing and saying. (R2) is totally aware of what is going on around him."

R2 was seen walking throughout the building on 6/15/16 through 6/16/16 without assistance of staff. R2 was in the dining room, the lounge area on east hall, sitting in the front lounge area in front of the dining room and was also seen walking toward the west area of the building.

1. R1's Progress note dated 6/15/16 at 6:37 PM completed by E1, Administrator documents, "Late Entry Incident involving male resident 6/13/16 approximately 7:30 PM. Staff reported male resident 'pinched' resident's breasts. PCP notified..."

R2's Progress note dated 6/15/16 at 6:53 PM by E1 states "Late Entry On June 13, 2016, staff reported incident involving a female resident's breast. PCP notified..."

E3, Certified Nurses Assistant (CNA) documents in writing on 6/13/16 the following: "I was walking into the east lounge area and saw (R2) on the left side of (R1). (R2) was bent over touching (R1's) left breast. I believe (R2) pinched her breast; it

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was not a grab or groping. I asked (R2) what he was doing; (R2) acted like he was brushing something off of (R1's) shirt in the chest area. I believe he touched her right breast at that time. I explained to him that was inappropriate....I reported the incident to the charge nurse and went on my break..."

E3 stated in interview on 6/15/16 at 11:54 AM the following; "I was in the lounge walking I came upon (R2) standing on (R1's) left side (R1) was in her wheelchair, (R2) had his right hand underneath (R1's) left breast . (R2) pinched her breast, (R1) did not say anything. I told (R2) that was inappropriate and (R1) looked at me and stated 'that was inappropriate' and then (R2) was acting like he was brushing crumbs off (R1's) blouse and then (R2) touched (R1's) right breast the same way again in front of me. I reported the incident to my charge nurse and then went on my break."

E1, Administrator confirmed on 6/16/16 at 2:04 PM, "I received a phone call at 7:37 PM on 6/13/16 from (E6), Asst Director of Nurses stating that (E3) told (E8), RN charge nurse that (R2) had touched (R1)'s breast. No, (E3) did not report this to me , (E3) reported the incident to (E8), charge nurse on that hall who reported it to (E6) who reported the incident to me."

On 6/15/16 at 10:45 AM R2 continued to have unrestricted access to other residents as R2 still shared a room with another resident. R2's bedroom was located within three rooms adjacent to where R1 still resided.

R2's Progress Notes dated 6/15/16 at 2:45 PM by Social Services documents "Spoke with (R2)

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F 225	Continued From page 7 about need for room move...." E1 confirmed on 6/15/16 at 4 PM, R2 was not moved to a private room until 6/15/16 at 3 PM. E1 stated on 6/16/16 at 2:04 PM "I thought (R2) was separated from the other residents by being in his room." 2. The facility's investigation forms given to employees dated 6/14/16 completed by E4, CNA documents "Yes a few times I saw (R2) cupping (R1's) breast and attempt to kiss (R1). " E4's written documentation dated 6/15/16 states " I came back to work around September/October 2015. I saw (R2) cup (R1's) breast a few months ago. On 6/16/16 at 8:56 AM E4 stated, "This incident involving (R1 and R2) him cupping her breast which I actually saw happened a few months ago. (R2) was cupping (R1's) breast and attempted to kiss (R1). (R1) did nothing, I moved (R1) to another area and told (R2) to go to his room, which he did do. I told the floor nurse that was available. The nurse stated she would report it. I did not call the Administrator because the floor nurse states she would report it. (R1) is very touchy-feely person and I don't know if (R2) was taking advantage of that. I feel (R2) is coherent enough to know better." E1, stated on 6/16/16 at 9 AM "I was never told about this incident, no one reported this to me so no report or investigation was completed regarding this incident. " The facility's policy dated 4/23/14 titled " Policy	F 225		

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F 225	Continued From page 8 and Procedure Regarding Abuse and Neglect, Misappropriation of Resident Property and Injuries of Unknown Origin" states "#1. All residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...#29 Reporting-Allegations of Abuse and Neglect: A facility employee or agent who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility administrator." The policy continues to state under #50 "If the incident involves suspected abuse, then the charge nurse shall assure that the suspected abuser has no further contact with the resident involved or with any other resident....#56 If another resident is the suspected perpetrator of the abuse, then the suspected resident shall be supervised 1:1 or kept physically separated from all other residents until further orders...the Administrator shall take all steps necessary to protect all residents from abuse until the alleged perpetrator can be evaluated." The form titled "Facility Data Sheet" dated 6/15/16 documents 111 residents reside in the facility.	F 225		
F 226 SS=F	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	F 226		

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by:
Based on record review, observation, and interview, the facility failed to operationalize their Abuse Prohibition Policy by failing to report a witnessed event of sexual abuse to the Administrator immediately and failing to report the allegation to the State survey and certification agency. The facility failed to remove the alleged perpetrator from continued resident contact, and failed to do a thorough investigation of alleged sexual abuse by R2 toward R1. R1 and R2 are two residents reviewed for abuse in a sample of three. These failures have the potential to affect all 111 residents residing in the facility.

Findings include:

The facility's Abuse Prohibition Policy dated 4/23/14 documents "All residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishments, and involuntary seclusion....A facility employee or agent who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility Adminstrator....If the incident involves alleged abuse, neglect, or incident of unknown origin, the incident will immediately be reported to the Administrator and the Administrator shall provide Illinois Department of Public Health (IDPH) with initial notice of the alleged abuse, neglect or incident of unknown origin by telefaxing to the Department a copy of a report of the incident completed immediately after the incident becomes known.....After an initial report of suspected abuse or neglect is sent to IDPH, the Administrator or designee shall investigate all alledged incidents of abuse or neglect....If the incident involves suspected abuse, then the charge nurse shall assure that the suspected

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abuser has no further contact with the resident involved or with any other resident....If the incident involves alleged abuse by another resident of the facility as the perpetrator of the abuse, the Administrator shall take all necessary stemps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated..."

R1's Physician Order Sheet dated June 2016 documents the following diagnoses: Dementia without Behavioral Disturbance, Heart Failure, Essential Hypertension and Anxiety Disorder. The Minimum Data Set for R1 dated 5/19/16 documents R1 with moderately impaired cognition and uses a wheelchair for mobility purposes. R1's Care Plan dated 6/10/16 documents that R1 is totally dependent on staff for all activities of daily living.

R2's Physician Order Sheet dated June 2016 documents the following diagnoses: Hepatic Failure, Cirrhosis of Liver, Diabetes Mellitus Type 2 and Hypertension. R2's Minimum Data Set dated 6/2/16 documents R2 as cognitively intact, independent in ambulation and walks with a cane.

On 6/16/16 at 5:49PM Z1, R2's Primary Care Physician stated " (R2) is very alert and oriented and understands what he is doing and saying. (R2) is totally aware of what is going on around him."

R2 was seen walking throughout the building on 6/15/16 through 6/16/16 without assistance of staff. R2 was in the dining room, the lounge area on east hall, sitting in the front lounge area in front of the dining room and was also seen walking toward the west area of the building.

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1. R1's Progress note dated 6/15/16 at 6:37 PM completed by E1, Administrator documents, "Late Entry Incident involving male resident 6/13/16 approximately 7:30 PM. Staff reported male resident 'pinched' resident's breasts. PCP notified..."

R2's Progress note dated 6/15/16 at 6:53 PM by E1 states "Late Entry On June 13, 2016, staff reported incident involving a female resident's breast. PCP notified..."

E3, Certified Nurses Assistant (CNA) documents in writing on 6/13/16 the following: "I was walking into the east lounge area and saw (R2) on the left side of (R1). (R2) was bent over touching (R1's) left breast. I believe (R2) pinched her breast; it was not a grab or groping. I asked (R2) what he was doing; (R2) acted like he was brushing something off of (R1's) shirt in the chest area. I believe he touched her right breast at that time. I explained to him that was inappropriate....I reported the incident to the charge nurse and went on my break..."

E3 stated in interview on 6/15/16 at 11:54 AM the following; "I was in the lounge walking I came upon (R2) standing on (R1's) left side (R1) was in her wheelchair, (R2) had his right hand underneath (R1's) left breast . (R2) pinched her breast, (R1) did not say anything. I told (R2) that was inappropriate and (R1) looked at me and stated 'that was inappropriate' and then (R2) was acting like he was brushing crumbs off (R1's) blouse and then (R2) touched (R1's) right breast the same way again in front of me. I reported the incident to my charge nurse and then went on my break."

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HERITAGE HEALTH-NORMAL	**509 NORTH ADELAIDE NORMAL, IL 61761**

(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 226	Continued From page 12 E1, Administrator confirmed on 6/16/16 at 2:04 PM, "I received a phone call at 7:37 PM on 6/13/16 from (E6), Asst Director of Nurses stating that (E3) told (E8), RN charge nurse that (R2) had touched (R1)'s breast. No, (E3) did not report this to me , (E3) reported the incident to (E8), charge nurse on that hall who reported it to (E6) who reported the incident to me." On 6/15/16 at 10:45 AM R2 continued to have unrestricted access to other residents as R2 still shared a room with another resident. R2's bedroom was located within three rooms adjacent to where R1 still resided. R2's Progress Notes dated 6/15/16 at 2:45 PM by Social Services documents "Spoke with (R2) about need for room move...." E1 confirmed on 6/15/16 at 4 PM, R2 was not moved to another room until 6/15/16 at 3 PM. E1 stated on 6/16/16 at 2:04 PM "I thought (R2) was separated from the other residents by being in his room." 2. The facility's investigation forms given to employees dated 6/14/16 completed by E4, CNA documents "Yes a few times I saw (R2) cupping (R1's) breast and attempt to kiss (R1). " E4's written documentation dated 6/15/16 states " I came back to work around September/October 2015. I saw (R2) cup (R1's) breast a few months ago. On 6/16/16 at 8:56 AM E4 stated, "This incident involving (R1 and R2) him cupping her breast	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145732	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 13 which I actually saw happened a few months ago. (R2) was cupping (R1's) breast and attempted to kiss (R1). (R1) did nothing, I moved (R1) to another area and told (R2) to go to his room, which he did do. I told the floor nurse that was available. The nurse stated she would report it. I did not call the Administrator because the floor nurse states she would report it. (R1) is very touchy-feely person and I don't know if (R2) was taking advantage of that. I feel (R2) is coherent enough to know better." E1, stated on 6/16/16 at 9 AM "I was never told about this incident, no one reported this to me so no report or investigation was completed regarding this incident. " The form titled "Facility Data Sheet" dated 6/15/16 documents 111 residents reside in the facility.	F 226		