STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145736	A. BUILDING _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

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F 000	INITIAL COMMENTS Incident Investigation IRI of 4/24/15/ IL 76877 - F225, F226, F323	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	F 225		

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

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F 225	Continued From page 1 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 and record review, the facility failed to immediately report a witnessed incident of inappropriate sexual behavior on 4/23/15 involving one resident (R1)'s behavior toward another resident (R2) out of 3. Findings include: On 5/1/15 at 10:45am, E2 (Director of Nursing) stated that he was notified of the incident that occurred on 4/23/15 at 8pm on 4/24/15 in the morning. E2 stated that he notified E1 (Administrator) and initiated the investigation and faxed the initial report to Illinois Department of Public Health on 4/24/15 at 7:25am. On 5/1/15 at 1:40pm, E1 (Administrator) stated that she should have been notified right away regarding the incident that occurred on 4/23/15 at 8pm. E1 stated that she was notified on 4/24/15 in the morning. E1 stated that she is the abuse coordinator for the facility. On 5/1/15 at 3:05pm, E3 (Certified Nursing Assistant) stated that she walked into R1's room at approximately 8pm on 4/23/15 and saw R1 with his penis in R2's mouth. E3 stated that R1 was standing over R2 holding her head. R2 was laying in bed. E3 stated that she immediately asked R1 what he was doing. E3 stated that R2	F 225		

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F 225	Continued From page 2	F 225		

did not respond. E3 stated that R1 backed away from R2. E3 stated that she yelled for the nurse to come in the room. On 5/1/15 at 12:40pm, E6 (Nurse) stated that she went into R2's room after E3 called for assistance. E6 stated that when she arrived in R2's room, she saw R1 with his pants open. E6 stated that she could not remember what E3 told her about witnessing R1's penis in R2's mouth. E6 stated that R2's eyes were closed when she observed R2 after the incident. E6 stated that she worked 7p until 7a the evening of the incident. E6 stated that she did not report the incident until the following morning to E2 (Director of Nursing). E6 stated that she was so disgusted by the incident. E6 stated that during the night after the incident, she checked on each resident twice an hour. E6 stated that she checked on R1 twice an hour to make sure he was in his room. R1 and R2 both have a diagnosis of dementia. R1 and R2 were residents on the dementia unit at the facility at the time of the incident.

The facility's initial summary to Illinois Department of Public Health (IDPH) is dated 4/24/15. The fax confirmation reads 7:25am on 4/24/15. The initial report reads R1's diagnosis is senile dementia, anxiety state, obsessive compulsive disorder, psychogenic paranoid psychosis, depressive disorder, anemia and cataract. The report reads "R1 observed with inappropriate sexual behavior toward peer."

The facility's Abuse Prevention Program policy dated 5/8/14 reads "Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator." E6 failed to immediately report the incident that

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F 225	Continued From page 3 occurred on 4/23/15 at 8pm until 4/24/15 in the morning.	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 implement their abuse policy on 4/23/15 when an incident occurred involving one resident (R1)'s inappropriate sexual behavior toward another resident (R2) out of 3. Findings include: On 5/1/15 at 3:05pm, E3 (Certified Nursing Assistant) stated that she walked into R1's room at approximately 8pm on 4/23/15 and saw R1 with his penis in R2's mouth. E3 stated that R1 was standing over R2 holding her head. R2 was laying in bed. E3 stated that she immediately asked R1 what he was doing. E3 stated that R2 did not respond. E3 stated that R1 backed away from R2. E3 stated that she yelled for the nurse to come in the room. On 5/1/15 at 12:40pm, E6 (Nurse) stated that she went into R2's room after E3 called for assistance. E6 stated that when she arrived in R2's room, she saw R1 with his pants open. E6 stated that she could not remember what E3 told her about witnessing R1's penis in R2's mouth. E6 stated that R2's eyes	F 226		

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F 226	Continued From page 4 were closed when she observed R2 after the incident. E6 stated that she worked 7p until 7a the evening of the incident. E6 stated that she did not report the incident until the following morning to E2 (Director of Nursing). E6 stated that she was so disgusted by the incident. E6 stated that during the night after the incident, she checked on each resident twice an hour. E6 stated that she checked on R1 twice an hour to make sure he was in his room. R1 and R2 both have a diagnosis of dementia. R1 and R2 were residents on the dementia unit at the facility at the time of the incident. On 5/1/15 at 10:45am, E2 (Director of Nursing) stated that he was notified on 4/24/15 in the morning about the incident that occurred on 4/23/15 at 8pm. The facility's Abuse Policy dated 5/8/14 reads "This facility prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. This is done by identifying occurrences and patterns of mistreatment, implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences." The facility did not implement the abuse policy of investigating the sexual inappropriate behavior incident that occurred on 4/23/15 promptly. The investigation did not begin until the next day.	F 226		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 5 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a plan of care to monitor and reduce the risk of a known inappropriate behavior for 1 of 3 residents R1, reviewed for inappropriate behaviors. Findings include: R1 is a 73 year old male who was admitted to the facility on 11/19/11. R1's diagnoses are dementia, parkinson's disease, anxiety disorder, depression, psychotic disorder and obsessive-compulsive disorder. R2 is a 70 year old female who was admitted to the facility 10/8/12. R2's diagnoses are dementia, parkinson's disease, major depressive disorder, osteoporosis, acute respiratory failure and hypertension. On 5/1/15 at 10a, R1 was observed in his room. R1 stated that he did not remember an incident that occurred with a female resident. On 5/1/15 at 12 noon, R2 was observed sitting in the dining room. R2 was not able to answer any questions. R2 was noted to be nonverbal. E7(Memory Care Director) stated on 5/1/15 at 12 noon that R2 only says a few words.	F 323		

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On 5/1/15 at 12:05pm, E7 (Memory Care Director/Social Service) stated that she does the care plans for the residents on the dementia unit. E7 stated that she wrote the care plan for R1 dated 4/17/15 which read "R1 demonstrates socially inappropriate behavior toward female residents." One of the interventions listed for this identified problem is "Monitor R1 for inappropriate behavior late after lunch." On 5/5/15 at 1:25pm, E5 (Care Plan Coordinator) stated that the date of the care plan problem is the date that a problem was identified. Surveyor asked E7 what problem was identified on 4/17/15 and E7 denied that anything occurred on 4/17/15 and R1 was supervised like every other resident on the dementia unit.

On 5/5/15 at 2:30pm, E4 (Certified Nursing Assistant) stated that on 4/17/15 at approximately 8p, she found R1 in R2's room with the lights out, privacy curtain closed and door shut. E4 stated that R1 and R2 were standing close to each other. E4 stated that she removed R2 from her room. E4 stated that R1 asked her where she was taking R2. E4 stated that R1 was not supposed to be in R2's room. E1 (Administrator) documented in R1 and R2's clinical notes regarding the incident on 4/17/15.

On 5/5/15 at 3p, E1 (Administrator) commented on the incident on 4/17/15 regarding R1 being in R2's room. E1 stated "Residents wander." E1 was not able to provide surveyor with an incident report regarding the incident on 4/17/15 when R1 was in R2's room. R2's clinical notes dated 4/17/15 at 14:08 reads "A male peer was found wandering in R2's room while R2 was there. Both residents were immediately separated and

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redirected. R2's POA (power of attorney) has been notified. Will continue to monitor residents." R1's clinical notes dated 4/17/15 at 14:03 read "R1 was found in female peer's room with female peer. Both residents were immediately seperated and redirected. Unable to reach family for R1. Will continue to monitor residents."

R1's BIMS (Brief Interview for Mental Status) score was 9 (out of 16) on R1's Minimum Data Set (MDS) dated 2/2/15. R2's MDS dated 2/21/15 reads R2 was unable to complete the interview for mental status. R2's assessment for mental status on R2's MDS reads short term and long term memory problem.

On 5/1/15 at 3:05pm, E3 (Certified Nursing Assistant) stated that she walked into R1's room at approximately 8pm on 4/23/15 and saw R1 with his penis in R2's mouth. E3 stated that R1 was standing over R2 holding her head. R2 was laying in bed. E3 stated that she immediately asked R1 what he was doing. E3 stated that R2 did not respond. E3 stated that R1 backed away from R2. E3 stated that she yelled for the nurse to come in the room. On 5/1/15 at 12:40pm, E6 (Nurse) stated that she went into R2's room after E3 called for assistance. E6 stated that when she arrived in R2's room, she saw R1 with his pants open. E6 stated that she could not remember what E3 told her about witnessing R1's penis in R2's mouth. E6 stated that R2's eyes were closed when she observed R2 after the incident. E6 stated that she worked 7p until 7a the evening of the incident. E6 stated that she did not report the incident until the following morning to E2 (Director of Nursing). E6 stated that she was so disgusted by the incident. E6

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F 323	Continued From page 8 stated that during the night after the incident, she checked on each resident twice an hour. E6 stated that she checked on R1 twice an hour to make sure he was in his room. R1 and R2 both have a diagnosis of dementia. R1 and R2 were residents on the dementia unit at the facility at the time of the incident. On 5/1/15 at 11am, E2 (Director of Nursing) stated that he initiated the investigation on 4/24/15 and sent R1 out to the hospital on 4/24/15. R1 was hospitalized in a psychiatric unit from 4/24/15 to 4/28/15. R1 returned to the facility on 4/28/15 and was moved off the dementia unit to another floor. On 5/1/15 at 3p, surveyor asked E1 if she thought R1 had the ability to get to the dementia floor. R1 returned back to the facility on a different floor after the incident on 4/23/15. E1 stated that she did not believe that R1 could get to the dementia floor. Surveyor asked E1 what type of supervision was in place to ensure that another incident would not happen again. E1 stated "Monitor closely."	F 323		