STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. BUILDING _____ B. WING _____	C 11/17/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTSIDE CARE CENTER	**601 N COLUMBIA WEST FRANKFORT, IL 62896**

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F 226	Continued From page 25 10's behaviors during the incident with R5. During an interview on 10/24/05 at 12:55 p.m., E 6 stated she did not attempt to use the call light. E6 said she tried to get E10 to respond to her verbally. Per written statement, E6 stated after E 10 left the shower room, E6 completed R5's shower. This action possibly destroyed any evidence. The nurses notes dated 10/18/05 indicate R5's physician and family were not notified until 3:00 p.m. on that date which is thirty three hours after the incident which is not accordance with their policy and procedure. The written statements of E5 and E6 indicate the incident occurring to R5 was not reported immediately to E5 (Director of Nursing), and the administrator was not notified immediately. The Director of Nursing was notified at 8:15 a.m. which is one hour and forty five minutes later. The conclusion to the investigation furnished by the facility states that Administrator was notified on 10/17/05 at 6:00 p.m. The nurses notes dated 10/21/05 at 9:05 a.m. indicate the local authorities were contacted until then which was four days later.	F 226		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1010h) The facility shall notify the resident's physician of any incident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a	F9999		

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F9999	Continued From page 26 period of 30 days. The facility shall obtain and record the physician's plan of care or treatment of such accident, injury or change in condition at the time of notification. 300.1210a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. 300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) 300.3240b) A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (Section 3-610 of the Act) 300.3240c) 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) 300.3240d) A FACILITY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A	F9999		

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F9999	Continued From page 27 RESIDENT SHALL ALSO REPORT THE MATTER TO THE DEPARTMENT. (Section 3-610 of the Act) 300.3240e) 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) Based on interviews, and records reviewed, the facility failed to ensure that one of five residents (R5) was free from sexual abuse; failed to implement written policies and procedures for preventing the sexual abuse of R5; failed to immediately stop the abuse from occurring to R5; failed to report the incident immediately to the Director of Nursing, Administrator and the supervisor; failed to immediately assess R5; failed to preserve any possible evidence by showering R5; failed to notify the physician, family and the local authorities in a timely manner; failed to immediately separate R5 from E10 on 10/17/05 when E10 was observed with E 10's hand under the shower chair; and the failed to intervene in a timely manner which resulted in R5 being sexually abused. Findings include:	F9999		

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F9999	Continued From page 28 Review of R5's admission sheet and physician's order sheet dated 9/23/05 identifies R5 as a 90 year old female admitted on 1/19/04 with the diagnoses of Alzheimer's disease and Dementia. A review of R1's Minimum Data Set (MDS) dated 8/8/05 indicates R5 is totally dependent on the staff for all activities of daily living and is severely impaired cognitively. Review of the incident report dated 10/18/05, indicates on 10/17/05 time of the incident is AM The type of incident was marked "other poss, sexual abuse." The type of abuse was identified as physical and or sexual abuse. E10 (Certified Nurses Aid - CNA) was assisting E6 (CNA) with R5's shower. E10 stated R5 needed to be checked for an impaction. E6 reported while E10 was checking for R5's impaction. E10 was making a "humping motion." "DON & ADON removed employee from building et (and) suspended pending investigation." The interview with E6 (CNA) on 10/24/05 at 12: 40PM and written statement dated 10/18/05, indicates at approximately 6:20 AM, E10 (CNA) stated R5 needed a shower due to being "messy" all night. The statement indicates at approximately 6:25AM to 6:30AM, E10 assisted E6 in transferring R5 to a shower chair. E6 indicated in the statement that E10 said to digitally stimulate R5 because E10 thought R5 was impacted. E6 explained after R5's shower if R5 had not had a bowel movement, E6 would report it to a nurse. The statement from E6 indicates E10 said if E6 wasn't going to check R5 for an impaction, E10 would. E6 indicated in the statement, there was no sense in doing an	F9999		

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F9999	Continued From page 29	F9999		

impaction check on R5. The statement indicates E10 insisted on the impaction check. E6's statement indicates E10 "gloved up and lubed" then proceeded to check R5 for an impaction. The statement indicates at first E6 thought E10 was trying to stimulate R5. Then E6 realized E 10 was moving the shower chair, then E10 started making a humping motion. E6 stated E10 would not respond to any conversation. E6 repeatedly tried to ask E10 to stop. E6 said to E 10, "if you don't feel any B.M. then she wasn't impacted". E6's statement indicates E10 did not respond. E6 observed E10's hand movements getting faster and faster and E10's humping motions to become rhythmical along with E10's hand movement. E6 said when E10 stopped E 10 pulled his gloved right hand from under the shower chair. E10 lifted the right gloved hand up, the gloved hand was covered in "bloody, thin B.M ." E6 said to E10, "leave and let me finish her shower," E10 acted like he didn't hear me. E10 just stayed bent down looking at R5's private area. E7 (CNA) stepped in the shower room to ask E6 a question. E6 requested E7's help in getting E10 out of the shower room. E10 was not listening to E6. E6 stated E10 threw the glove soiled with feces and blood in the trash receptacle. Then E6 said E10 left the shower room. E6 completed R5's shower. E6 did not report the incident to E5 (Director of Nursing Service) until 8:15 a.m. on 10/17/05. During an interview with E6
on 10/24/05 at 12:40 PM E6 said she did not use the call light to call for help. E6 stated R5 did not show any expression during this incident. E6 stated during an interview on 10/25/05 at 1:05 PM E10 looked like E10 was having sex with his hand. E10 walked in the shower room as one

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F9999	Continued From page 30 person and left acting like another person. An interview with E11 (CNA) on 10/27/06 at 8:45 AM indicated E11 entered the shower room to ask E6 a question. The written statement by E11 (CNA), indicated on 10/17/05 at approximately 6: 30 AM, E10 was observed bent over R5 "digging out" an impaction. E11's statement said "It looked as if he was doing something more, in a sexual way. His (Arm) hand was jerking around and his whole body was moving (like he was hunching) back & forth." E11 observed R5's body moving more than it should. E11's statement indicated E6 asked E10 to leave the shower room. E11 said E10 was like in his own world. E11's statement indicated around five or ten minutes later, E10 was observed in room 209 leaning over the empty bed of R9. The written statement was confirmed by interview on 10/27/ 05 at 8:45 AM with E11. An interview with E7 (CNA), on 10/24/05 at 1:35 PM indicated, on 10/17/05 at approximately 6:30 AM, E7 heard E6 telling someone in the shower room to get out of there. E7 said she thought it was another resident. When E7 opened the door, E6 and E10 were in the shower room. R5 was in the shower chair. E10 was bent over the shower chair. E10 opened his eyes and stood up. E7 observed four fingers on the right gloved hand with blood and BM on them. The interview with E7 indicated E6 asked her to help get him out of there. E7 said E10 removed the glove as E10 "stormed" by E7, E10 put the glove in the trash can. E10 left the shower room mumbling something E7 could not understand. Neither E11 or E7 reported the incident.	F9999		

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F9999	Continued From page 31	F9999		

The written statement of E5 indicates after E6 notified E5 at 7:45am concerning E10's behavior to R5 in the shower room. E6 stated she was unsure exactly what E10 was doing to R5. E6 stated E10 appeared to "Have convulsions" as if he orgasmed. E6 stated when E10 was doing this, E6 was telling him to stop and E10 did not appear to hear E6. "It was like he was in a trance ".

The review of the incident report dated 10/18/05 indicates E10 has been suspended pending an investigation.

Per review of R5's nurses notes, the family was not notified of the 10/17/05 incident until 3:05 PM on 10/18/05. E5 (Director of Nursing) was not made aware of the allegation of sexual abuse until 10/17/05 at 8:45 AM after E5 had observed E10 with unusual behavior as described on E5's written statement as follows: E12 (CNA) at approximately 6:20 AM observed, E10 slumped over the end of R9's bed sound asleep. E5 attempted to awaken E10 three times. On the fourth attempt to awaken E10, E10 stood straight up, rubbed face vigoursly with the palm of hands. E10 turned to the sink in Room 209. E10 began washing his hands. While E10 was washing his hands, E10 leaned his head on the mirror as if he was going to sleep again. E5 raised E10 up by his shoulders and asked if E10 was "O.K." E10 did not respond. E5 escorted E10 to the North Hall Nurses Station. During the walk to the nurses station E5 stated, E10 was unsteady on feet. E5 asked E10 if he had any medical conditions that would make E10 act this way. E 10 did not respond. E5 checked E10's blood sugar in the medicine room. E10 was mumbling

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F9999	Continued From page 32	F9999		

words which were incoherent. E5 escorted E10 to the Director of Nursing's office. E10 was seated and was leaning over in the chair with his head between his knees. E5 made several attempts for E10 to respond, when E10 did not respond E5 called 911 at approximately 6:45 a. m. The ambulance arrived at the facility at 7:05 AM to transport E10 to the emergency room for evaluation. When the ambulance crew arrived at E5's office with the stretcher, E10 started talking to the ambulance crew and refused to be transferred to the local hospital. E10 walked out of the facility at approximately 7:30 AM.

E2 had observed E10's unusual behavior as per E2's statement as follows: E2 indicates her arrival to the facility on 10/17/05 at 6:45 AM. E2 attempted to talk to E10, but E10 would not respond. E10 was moved to E5's office, E10 was rocking in the chair and leaning forward. When the local ambulance arrived, E10 did not seem to understand what was occurring until E10 was placed on the stretcher. Then E10 refused to go to the emergency room for assessment. E2 walked with E10 to the front door then E10 left the facility to walk home.

According to the nurses notes dated 10/18/05 at 3:00 PM, R5's physician and family were not notified of the sexual abuse which occurred on 10 /17/05. The nurses notes on 10/19/05 indicate a late entry on 10/18/05 of a body audit head to toe done. That nurses note indicated "No areas were found." This was confirmed by interview with E2 on 10/25/05 at 3:00 PM. E2 stated during the interview on 10/25/05 at 3:00 PM that R5 was assessed on 10/17/05 no specific time was stated.

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F9999	Continued From page 33 The written statements furnished by the facility indicate E13 (LPN) and E14 (LPN) examined R5 immediately after lunch on 10/17/05. E13 and E 14 removed a brown semi-hard fecal impaction without any blood or blood in the stool. R5 did not show any signs of discomfort during the procedure. E13 and E14 examined R5's rectum and perineal area, there was not any signs of redness or bruising. The investigation report completed by the facility on 10/28/05 states E2 performed a head to toe assessment of R5 on 10/17/05 in the AM. The investigation report states E2 did not find any signs of abuse. The report indicates E2 went to the shower room to check the trash receptacle. No bloody glove was found. A statement written by E15 (Housekeeper) indicates E15 was in the shower room at 6:30 AM and did not see any thing out of the ordinary. E15 states that she did not observe a bloody glove in the trash receptacle. E15 states that receptacles are emptied approximately every hour. According to the facility's policy dated 7/99 on Abuse sexual, the basic responsibility is all staff. "The purpose of the policy is to provide a safe environment for all residents and keep all residents free from abuse from an individual. The Policy prohibits abuse on any form with a high emphasis on (But not limited to) prevention. " The definition of "sexual abuse includes sexual harassment, sexual coercion, or sexual assault." "Any allegation of abuse shall be reported	F9999		

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F9999	Continued From page 34 immediately to the supervisor, Administrator, and Director of Nursing. The person in question shall be clocked out and sent home pending the investigation." "The resident shall be assessed immediately following the reporting of abuse. The Administrator, Director of Nursing, family, and physician shall be immediately notified. All bed linen shall be saved and the resident will be sent to the emergency room for an evaluation. The police shall be immediately notified." The facility failed to separate E10 from R5 during the incident on 10/17/05 at 6:20 a.m. in the south shower room. On 10/25/05 at 12:00 noon, the south shower room was observed. A call light is on the south wall to the left of the shower. The review of the facility's investigation into the incident indicates E6, E7, and E11 witnessed E 10's behaviors during the incident with R5. During an interview on 10/24/05 at 12:55 p.m., E 6 stated she did not attempt to use the call light. E6 said she tried to get E10 to respond to her verbally. Per written statement, E6 said after E10 left the shower room, E6 completed R5's shower possibly destroying any evidence. The nurses notes dated 10/18/05 indicate R5's physician and family were not notified until 3:00 p.m. on that date which is thirty three hours after the incident. This is not accordance with their policy and procedure. The written statements of E5 and E 6 indicate the incident occurring to R5 was not reported immediately to E5 (Director of Nursing), and the administrator was not notified immediately. The Director of Nursing was notified at 8:15 a.m. which is one hour and forty five minutes later. There is not any	F9999		

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F9999	Continued From page 35 documentation of when the administrator was notified. The nurses notes dated 10/21/05 at 9 :05 a.m. indicate the local authorities were contacted, which was four days later. The bloody, bowel movement glove was not preserved . R5 was not sent to the local emergency room for assessment. (A)	F9999		