STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146071	A. BUILDING _____ B. WING _____	C 12/22/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILTMORE REHABILITATION & NURSING CENTER	**1701 WEST 5TH AVENUE BELVIDERE, IL 61008**

(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 324	Continued From page 27 falling stars checking on them as you pass by their room or their person or when going through a room".	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4) 300.3240a) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a	F9999		

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F9999	Continued From page 28 resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Requirements were not met as evidenced by the following: Based on interview, record review and observation, the facility neglected to protect confused female residents, and supervise R2 who repeatedly exhibited inappropriate sexual behavior toward female residents between 4/27/06 and 12/8/06. These failures apply to 1 aggressor (R2), 3 known victims (R9, R12 and R16) and an unknown number of confused female resident victims that were unidentified in nurses notes described on 15 different occasions for over a period of 7 months. The examples include: The December Physician's Orders for Medications and Treatment Sheet (POS) shows R2 is a 94 year old male resident admitted on 1/10/05 with diagnoses including Alzheimers, Congestive Heart Failure, Status Post Porcine valve, Incontinence, Hypertension, Depression, Brief Reactive Psychosis, Organic Mental Syndrome/Dementia with associated Psychotic or Harmful Behaviors.	F9999		

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F9999	Continued From page 29 R2's assessment of 10/5/06 shows he is moderately impaired in daily decision making and that he requires supervision. The Nurse's Notes that are available show R2 began exhibiting behaviors on 4/27/06 at 9:30pm. R2 was inappropriately touching female residents. The Nurse's Notes document 15 different occasions of grabbing, touching other residents on the breast, between the legs, kissing residents, wheeling into female resident's room, removing clothing in dining room and resisting staff attempts to redirect behavior. The Social Services Progress Notes: 7/21/05 note shows that R2 has shown similar behaviors in past several years and prior to admission. 1/12/06 note shows R2 continues to be inappropriate and exhibiting sexual behavior towards staff and peers if he is seated too close. A 7/18/06 note shows R2 will attempt to touch a peer inappropriately on breast or upper thigh and after being redirected will forget the occurrence and make another attempt at a later time. A 7/27/06 note shows R2 was sexually inappropriate to the wife and another family member of R2's roommate. A 10/12/06 note shows R2 continues to exhibit inappropriate sexual behaviors, verbally and physically touching or attempting to touch staff and peers on breasts sometimes attempting to put his hands under female's shirts. R2 becomes upset when attempting to redirect. Sexual inappropriateness occurs 1 to 5 times a week. A 11/12/06 note shows R2 has been counseled numerous times by staff. He continues to exhibit grabbing and is not easily redirected. A 12/8/06 note shows Nursing reports that R2 has been exhibiting sexual behavior of touching female	F9999		

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F9999	Continued From page 30 resident's breasts. R2's Care Plan dated 10/12/06 shows sexual behaviors occurs 4 to 6 times a week. The goal is to have sexual behaviors 5 times a week. The approaches for this behavior is to direct away from female peers, do not seat close to female peers in dining room, when self-propelling wheelchair observe his activities around female peers and to report to nursing all inappropriate behaviors. On 12/20/06 at 3:15pm, E1 (Administrator) said there is no Policy and Procedure on 1:1 supervision. "We have been doing 15 minute checks on R2 since 12/8/06." On 12/20/06 at 2:30pm, E3 Assistant Director of Nursing (ADON) said R2 is persistent. "He keeps returning to the same resident and his behaviors are increasing. He has approached R9, R12 and R16 that I know of." On 12/20/06 at 3:00pm, E2 Director of Nurses (DON) said 1:1 is the same as 15 minutes checks. Someone is not with R2 all the time when he is up. On 12/19/06 at 2:20pm, E4 Social Services Director (SSD) said R2 is ambulatory with a wheelchair. He goes to the Activity room to seek out female residents. After redirecting he returns to the same person. He likes to touch breasts. R2's behaviors are increasing. His alertness fluctuates. On 12/19/06 at 1:30pm, E7 Certified Nurses Aide (CNA) said, "We are supposed to keep R2 from going into other residents' rooms by not putting	F9999		

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F9999	Continued From page 31 him in his wheelchair. We put him in a stationary chair." On 12/20/06 at 1:15pm, R7 said she has known R2 for 60 years. "He has been a toucher all the time she has known him. He can't keep his hands off women. He prays on paraplegic females or those who can't defend themselves. He roams in and out of residents' rooms at night. He has come into my room at night. I tell him to get out or call the staff." On 12/19/06 at 1:00pm R8 said she saw R2 touching a female resident, and "I called a nurse." The facility's Policy and Procedure on Abuse and Neglect under Prevention, documents: The Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect or misappropriation of resident property is a risk for occurring. Under Reporting, the Policy documents that the facility will report all allegations and substantiated occurrences of abuse to the state agency as designed by state law. R2's room was observed to be located next to the end room of the hall, and 7 rooms distance from the nurses station. (A)	F9999		