STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. BUILDING _____ B. WING _____	C 01/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE NUR & REHAB CENTER	**2649 EAST 75TH ST CHICAGO, IL 60649**

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F 000	INITIAL COMMENTS Complaint #0684852 / IL25996 - No deficiencies. Complaint # 0684890/ IL26035 - No deficiencies. Complaint # 0684875/ IL26021 - F324 and F224 cited. A partial extended survey was conducted.	F 000		
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS 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 interviews and record review the facility neglected to supervise a resident (R10) who has a behavior of wandering in and out of residents' rooms. This neglect to supervise and monitor R10's whereabouts at all times resulted in R10 entering the room of R11 at 1:00AM the morning of 11/23/06 and sexually assaulting R11. R10 was sent to a local hospital but returned within hours and continued to reside on the same floor as R11, as well as continuing to wander in and out of other residents rooms putting them at risk as well. The above failure resulted in an Immediate Jeopardy. E1 (administrator) and E3 (Director of nurses) were notified of the Immediate Jeopardy on 01/02/07, at approximately 1:40Pm. The Immediate Jeopardy was determined to have started on 11/23/06 when R10 entered the room	F 224		1/3/07

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

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F 224	Continued From page 1 of R11 at 1:00AM and sexually assaulted R11. Findings include: R10 is a 79 year old resident who was admitted to the facility on 11/20/06 with diagnoses including "Altered Mental Status and Dementia." R10 was admitted to the facility 3 days prior to R10 sexually assaulting R11. Record review of the facility's abuse files included an incident summary dated 11/23/06 at 1:00AM indicated documentation as follows: "R10 found naked in room with patient (R11) in room 340 bed 1. R10 was kneeling down with R11's penis in R10's hand climbing into bed with the male resident. R10 had pulled R11's underwear down. R10 became agitated when approached. R10 threatened staff and writer states, "I'm going to kill you, I will f---- you up." Review of R10's clinical record indicated nurses notes dated 11/23/06 at 1:00AM as follows: "R10 found in room 340 with R11. R10 was naked kneeling down with R11's penis in his hand. R10 was observed climbing into bed with R11 while attempting to remove R11's underwear when discovered R10 became very agitated and threatened writer. R10 states "I"m going to kill you", I will f--- you up". R10 was redirected to chair by nurse station by writer to monitor R10 1:1". Clinical record review indicated that R10 was sent to a local hospital for a psych eval on 11/23/06 at 2:10AM but R10 returned to the facility approximately 3 1/2 hours, on 11/23/06 at 5:30AM.	F 224		

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F 224	Continued From page 2 Nurses' notes dated 11/23/06 at 2:45Pm documentation as follows: "R10 continues to ambulate down hallway". Nurses' notes dated 11/24/06 indicates documentation for R10 as follows: "R10 up ambulatory around unit continues to wander in and out of rooms and doors on unit. R10 remain agitated". Surveyor did not note any documented 1:1 monitoring at this time even though R10 had this sexual encounter with another resident less that 24 hours earlier. On this day at approximately 3:25Pm E1 (administrator) brought E4 and E5 (both nurses) to the conference room to talk to surveyor regarding R10 receiving 1:1 monitoring upon R10's return to the facility. E4 stated, "I started 1:1 on R10 on 11/24/06 and it continued until I left at 3:30Pm". E4 was further interviewed regarding R10 continuing to receive 1:1 monitoring throughout the evening. E4 stated, "I don't know what happened after I left". E5 was later interviewed. E5 stated, "R10 was assigned a 1:1 during the 7:00 to 3:00 shift and they wanted me to continue this until R10 was picked up by ambulance, I assigned a CNA ". Surveyor questioned E5 as to who informed her of R10 being on 1:1 and who asked her to continue it. E5 stated, "E4 asked me to continue the 1:1". This interview with E5 is in conflict with E4's earlier interview when E4 told surveyor "I don't know what happened after I left" (in response to question by surveyor regarding continuation of 1:1 for R10)	F 224		

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F 224	Continued From page 3 Upon further interview neither E4 or E5 could provide documentation of 1:1 monitoring for R10. Neither E4 nor E5 could provide an explanation as how R10 continued to wander in and out of residents rooms on 11/24/06 if there was 1:1 monitoring. On 11/30/06 at approximately 3:20PM, R10 and R11 were both observed in the same activity group on the 3rd floor of the facility. During daily status on this day at approximately 4:40PM, E1, E2 and E3 (Director of nurses) were interviewed regarding separation of R10 from R11 especially since R10 continues to wander in and out of residents' rooms. E1 stated that R10 receives 1:1 monitoring now and that R10 and R11 are both cognitively impaired. E3 added, "I just spoke with our psychiatrist who is here in the building, and he (psychiatrist) said that a lot of dementia residents are hypersexual and R10's behavior may continue on another floor". Surveyor continued to interview E1, E2 and E3 with regard to supervision of R10. E1 added "R10 was supervised", however upon further interview E1 could not provide evidence of monitoring R10 by the facility staff. On the next day of the survey (12/04/06) R10 was observed moved to another floor in another room with a sitter present. (R10 was moved 7 days after R10 had sexually assaulted R11 and after prompting by surveyor). On 12/06/06 at approximately 9:05AM in the 1st floor conference/exam room surveyor interviewed E10 (nurse on duty who found R10 in sexual encounter on 11/23/06) regarding what he	F 224		

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F 224	Continued From page 4 observed on the night R11 was assaulted by R10. During this interview E10 described what he had observed on the night of this incident exactly as he had documented it in his nurses' notes and on the incident summary. E10 added that R10 has wandered up and down the hallways and in and out of residents's rooms since R10's admission on 11/20/06 and R10 was not easily redirected. Upon further interview E10 stated, "At the time of R10 going into R11's room I was on the phone trying to get a hold of Z1 because R10 had been up all night, agitated and wouldn't settle down. The 3 CNAs' that night were busy with changing our heavy wetters and watching other wandering residents including R12 who is blind and also a wanderer. There was no special monitoring done for R10 until after this incident. I then assigned a CNA (certified nurse assistant) for 1:1 for R10, even though this was hard with only 3-4 CNAs' and 76 - 78 residents". E10 further added, "R10 was still hard to manage even on 1:1 monitoring". Upon further interview E10 added, "I can't say if 1:1 continues once I leave in the morning or not". E10 finally stated, "I'm not sure I can say that any resident on the 3rd floor is safe because of the wanderers who need constant supervision and only 3-4 CNAs' with 76 - 78 residents. It gets overwhelming at times." On 12/04/06 at approximately 12:30PM Z1 was interviewed by surveyor (per phone) about receiving calls from the facility regarding R10's behavior including wandering and sexual encounter. Z1 stated, "I've gotten a lot of calls from the facility regarding R10 and I did get a call	F 224		

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F 224	Continued From page 5 11/23/06 after R10 returned from a psych eval at the hospital". Upon further, interview Z1 continued to say, "I don't remember. I get so many calls, but I have gotten at least another call since R10 came back from his psyche evaluation. I agree that something should be done by the facility about R10." The facility had knowledge of R10's wandering going in and out of other residents' rooms but neglected to know where R10 was at all times. This neglect put all residents on the 3rd floor at risk and had negative consequences for R11. On 12/20/06, the facility's "Abuse, Mistreatment, Neglect, Misappropriation of Property Policy and Procedure", revised 7/99 was reviewed. This policy defines "Sexual Abuse -- Includes but not limited to sexual harassment, sexual coercion or sexual assault." This policy also, requires under section, "9. When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that another resident of the facility is a perpetrator of the abuse, the resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of the resident as well as the safety of other residents and employees of the facility." The Immediate Jeopardy was identified on 11/30/06 at approximentaly 11:30 AM; and determined to have begun on 11/23/06, when R10 entered the room of R11 at 1:00AM and sexually assaulted R11. E1 (administrator) and E3 (Director of Nurses) were notified of the Immediate Jeopardy on 01/02/07, at	F 224		

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F 224	Continued From page 6 approximately 1:40PM. The facility faxed an abatement plan on 01/03/07. The Immediate Jeopardy was removed and corrected, on 12/20/06 at approximately 4:00 PM. The facility took the following steps to remove the Immediate Jeopardy. Actions taken: 1. R10 was discharged from the facility on 12/20/06 to a local hospital. After discharge from this local hospital, R10 did not return to the facility but was transferred to another facility that could best meet his behavioral needs. R11 remains at the facility with no other additional incident or display of ill effects from the incident of 11/23/06. 2. The IDT (Interdisciplinary team) is reviewing all incidents in the facility and completing all investigations and plan to meet at least 2 times weekly. Any resident exhibiting behaviors identified by the IDT will be closely observed for 72 hours. All results will be reviewed by the Medical Director as well as QA committee. 3. The facility did an audit and found currently there was no registered sex offenders in the facility. 4. The facility with IDT identified residents with wandering and sexual inappropriate behaviors. Date of completion: 01/02/07 and On-going with QA monthly and as needed. 5. Inservices of staff were initiated and continues for all staff including:	F 224		

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F 224	Continued From page 7 a) Abuse policy and procedures b) proper intervention related to abuse and behaviors c) immediate separation and documentation. c) notification of supervisors and Administrator. d) assessments Date of completion: 01/02/06 and On-going as needed/ QA will monitor monthly and as needed. 6. The facility reviewed and updated the care plans of each identified wanderer. 7. All residents identified as wanderers as well as residents with sexual inappropriate will be placed on every 2 hour checks. If no inappropriate behaviors are exhibited after 2 weeks they will be placed on every 4 hours checks for 4 weeks. If no inappropriate behaviors are identified they will be placed on every 8 hours checks for 8 weeks. A tool was developed for staff to utilize with every 2 hour room checks of identified wanderers and high risk residents. Date of completion: 01/02/07 and On-going as needed/QA will monitor monthly and as needed. 8. Administrator or designee will review residents who exhibit wandering and sexual behaviors 2 times weekly with the IDT to assure accurate interventions and documentation Date of completion: 01/02/07 and On-going with QA monitoring monthly and as needed. 9. All incidents will be reviewed at daily meeting and investigated with a monitoring tool put in place when required.	F 224		

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F 224	Continued From page 8 10. A summary of all incidents and reported abuse is presented to QA committee monthly for 90 days. Date of completion: 01/02/07 and On-going with QA on a monthly basis initially and as needed.	F 224		
F 324 SS=J	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to adequately supervise R10. Because of this failure one resident in the sample (R11) was sexually assaulted by R10. R10 is new to the facility and has a history of wandering . The facility's failure to monitor R10 and be aware of R10's whereabouts resulted in R10 wandering into the room of R11 at 1:00 in the morning, sexually assaulting R11. Upon R10's return to the facility approximately 3 hours later following a psych evaluation at a local hospital, R10 was placed back on the same floor as R11 and continued to wander, going in and out of resident's rooms. This failure resulted in an Immediate Jeopardy. E1 (Administrator) and E3(Director of nurses) were informed of the Immediate Jeopardy on 01/02/07 at approximately 1:40Pm. The immediate jeopardy was determined to have started on 11/23/06 when R10 entered the room of R11 at 1:00 in the Am and sexually assaulted R11.	F 324		1/3/07

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F 324	Continued From page 9 Findings includes: On 11/30/06 at approximately 10:30AM E1 (administrator) was interviewed regarding abuse in the facility, specifically sexual abuse. E1 stated, "Yes, there is a sexual abuse I'm working on". E1 then provided surveyor with his abuse files. Record review of the facility's abuse files included an incident summary dated 11/23/06 at 1:00AM indicated documentation as follows: "R10 found naked in room with patient (R11) in room 340 bed 1. R10 was kneeling down with R11's penis in R10's hand climbing into bed with the male resident. R10 had pulled R11's underwear down. R10 became agitated when when approached. R10 threatened staff and writer states"I"m going to kill you, I will f---- you up". Review of R10's clinical record indicated nurses notes dated 11/23/06 at 1:00Am as follows: "R10 found in room 340 with R11. R10 was naked kneeling down with R11's penis in his hand. R10 was observed climbing into bed with R11 while attempting to remove R11's underwear when discovered R10 became very agitated and threatened writer. R10 states "I"m going to kill you", I will f--- you up" R10 was redirected to chair by by nurse station by writer to monitor R10 1:1". . Further review of this file indicated E2 (assistant administrator) did an interview with E10 (nurse on duty the night of the incident) on 11/24/06. This interview indicated that E10 was at the nurses station when he observed R10 going into the room of R11 and later went to see why R10	F 324		

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had gone into the room. When E10 arrived, R10 was climbing into bed with R11. It was further documented that although E10 did not witness R10 pulling down R11's underwear it was assumed that R10 did it since R11's underwear was down and R10's hand was near R11's privates. Knowing this behavior was inappropriate, E10 commenced to separate R10 and R11. At that point R10 became very agitated with E10 and was verbally aggressive. R10 was sent to a local hospital for a psychological evaluation at 2:10Am following this incident and returned to the facility at 5:30Am (approximately 3 hours later).

Clinical record review dated 11/24/06 indicates staff 's documentation as follows: "R10 up ambulatory around unit continues to wander in and out of rooms and doors on unit. R10 remain agitated." There was no documented 1:1 monitoring at this time even though R10 had this sexual encounter less that 24 hours earlier.

Upon interview with E1 regarding R10 going out to the hospital and returning with the same behavior of wandering in and out of rooms, E1 stated, "R10 had 1:1 monitoring". Later this day at approximately 3:25Pm E1 (administrator) brought E4 and E5 (both nurses) to the conference room to talk to surveyor regarding R10 receiving 1:1 monitoring upon R10's return to the facility. E4 stated, "I started 1: 1 on R10 on 11/24/06 and it continued until I left at 3:30Pm". Upon further interview regarding R10 continuing to receive 1:1 monitoring throughout the evening, E4 stated, "I don't know what happened after I left."

E5 was later interviewed. E5 stated, "R10 was

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assigned a 1:1 during the 7:00 to 3:00 shift and they wanted me to continue this until R10 was picked up by ambulance, I assigned a CNA ". Surveyor questioned E5 as to who informed her of R10 being on 1:1 and who asked her to continue it. E5 stated, "E4 asked me to continue the 1:1".

This interview with E5 is clearly in conflict with E4's earlier interview when E4 told surveyor "I don't know what happened after I left (in response to question by surveyor regarding continuation of 1:1 for R10).

Upon further interview neither E4 or E5 could provide documentation of 1:1 monitoring for R10. Neither E4 nor E5 could provide an explanation as how R10 continued to wander in and out of residents rooms on 11/24/06 if there was 1:1 monitoring.

On 11/30/06 at approximately 3:20Pm R10 and R11 were observed by surveyor in an activity group in the 3rd floor activity room.

During daily status on this day at approximately 4:40Pm, E1, E2 and E3 (Director of nurses) were interviewed regarding separation of R10 from R11 especially since R10 continues to wander in and out of residents' rooms. E1 stated that R10 receives 1:1 monitoring now and that R10 and R11 are both cognitively impaired. E3 added, "I just spoke with our psychiatrist who is here in the building, and he (psychiatrist) said that a lot of dementia residents are hypersexual and R10's behavior may continue on another floor".

However the next morning (12/04/06) R10 was observed moved to another floor in another room

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with a sitter present. (R10 was moved 7 days after R10 had sexually assaulted R11 and after prompting by surveyor as well, this was the 1st time surveyor observed R10 receiving 1:1 monitoring by staff).

On 12/06/06 at approximately 9:05Am in the 1st floor conference/exam room surveyor interviewed E10 (nurse on duty who found R10 in sexual encounter on 11/23/06) regarding what he observed on the night R11 was assaulted by R10.
During this interview E10 described what he had observed on the night of this incident exactly as he had documented it in his nurses' notes and on the incident summary. E10 added, " R10 has wandered up and down the hallways and in and out of residents's rooms since R10's admission on 11/20/06 and R10 has not been easily redirected".
Upon further interview E10 stated, " At the time of R10 going into R11's room (at 1:00 in the morning) I was on the phone trying to get a hold of Z1 because R10 had been up all nite, agitated and wouldn't settle down. The 3 CNAs' that night were busy with changing our heavy wetters and watching other wandering residents including R12 who is blind and also a wanderer". E10 continued, "There was no special monitoring done for R10 until after this incident. I then assigned a CNA (certified nurse assistant) for 1:1 for R10, even though this was hard with only 3-4 CNAs' and 76 - 78 residents". E10 further added, " R10 was still hard to manage even on 1:1 monitoring". Upon further interview E10 added, "I can't say if 1:1 continues once I leave in the morning or not".

E10 finally stated, "I'm not sure I can say that any

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE NUR & REHAB CENTER	2649 EAST 75TH ST CHICAGO, IL 60649

(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 13 resident on the 3rd floor is safe because of the wanderers who need constant supervision and only 3-4 CNAs' with 76 - 78 residents. It gets overwhelming at times." On 12/04/06 at approximately 12:30PM Z1 was interviewed by surveyor (per phone) about receiving calls from the facility regarding R10's behavior including wandering and sexual encounter. Z1 stated, "I've gotten a lot of calls from the facility regarding R10 and I did get a call 11/23/06 after R10 returned from a psych eval at the hospital". Upon further interview Z1 continued to say, "I don't remember, I get so many calls, but I have gotten at least another call since R10 came back from his psych evaluation. I agree that something should be done by the facility about R10." R10 is a 79 year old resident who was admitted to the facility on 11/20/06 with diagnoses including "Altered Mental Status and Dementia. R10 was admitted to the facility 3 days prior to R10 sexually assaulting R11. The facility had knowledge of R10's going in and out of other residents' rooms but failed to know where R10 was at all times. This failure put all residents on the 3rd floor at risk and had negative consequences for R11. The Immediate Jeopardy was identified on 11/30/06 at approximately 11:30 AM; and determined to have begun on 11/23/06, when the facility failed to adequately supervise one resident (R10) from entering the room of R11 at 1:00AM and sexually assaulted R11. E1 (administrator) and E3 (Director of Nurses) were notified of the Immediate Jeopardy on 01/02/07,	F 324		

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F 324	Continued From page 14 at approximately 1:40Pm. The facility faxed an abatement plan on 01/03/07. The Immediate Jeopardy was removed and corrected, on 12/20/06 at approximately 4:00 PM. The facility took the following steps to remove the Immediate Jeopardy. Actions taken: 1. R10 was discharged from the facility on 12/20/06 to a local hospital, after discharge from this local hospital, R10 did not return to the facility but was transferred to another facility that could best meet his behavioral needs. R11 remains at the facility with no other additional incident or display of ill effects from the incident of 11/23/06. 2. The IDT (Interdisciplinary team) is reviewing all incidents in the facility and completing all investigations and plan to meet at least 2 times weekly. Any resident exhibiting behaviors identified by the IDT will be closely observed for 72 hours. All results will be reviewed by the Medical Director as well as QA committee. 3. The facility did an audit and found currently there was no registered sex offenders in the facility. 4. The facility with IDT identified residents with wandering and sexual inappropriate behaviors. Date of completion: 01/02/07 and On-going with QA monthly and as needed. 5. Inservices of staff were initiated and continues for all staff including:	F 324		

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F 324	Continued From page 15 a) Abuse policy and procedures b) proper intervention related to abuse and behaviors c) immediate separation and documentation. c) notification of supervisors and Administrator. d) assessments Date of completion: 01/02/06 and On-going as needed/ QA will monitor monthly and as needed. 6. The facility reviewed and updated the care plans of each identified wanderer. 7. All residents identified as wanderers as well as residents with sexual inappropriate will be placed on every 2 hour checks. If no inappropriate behaviors are exhibited after 2 weeks they will be placed on every 4 hours checks for 4 weeks. If no inappropriate behaviors are identified they will be placed on every 8 hours checks for 8 weeks. A tool was developed for staff to utilize with every 2 hour room checks of identified wanderers and high risk residents. Date of completion: 01/02/07 and On-going as needed/QA will monitor monthly and as needed. 8. Administrator or designee will review residents who exhibit wandering and sexual behaviors 2 times weekly with the IDT to assure accurate interventions and documentation Date of completion: 01/02/07 and On-going with QA monitoring monthly and as needed. 9. All incidents will be reviewed at daily meeting and investigated with a monitoring tool put in place when required.	F 324		

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F 324	Continued From page 16 10. A summary of all incidents and reported abuse is presented to QA committee monthly for 90 days. Date of completion: 01/02/07 and On-going with QA on a monthly basis initially.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.3240a) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	F9999		

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F9999	Continued From page 17 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. 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 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 interviews and record review the facility neglected to supervise a resident (R10) who has a behavior of wandering in and out of residents' rooms. This failure to supervise and monitor R10's whereabouts at all times resulted in R10 entering the room of R11 at 1:00AM the morning of 11/23/06 and sexually assaulting R11. R10 was sent to a local hospital but returned within hours and continued to reside on the same floor as R11, as well as continuing to wander in and out of other residents rooms putting them at risk as well.	F9999		

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F9999	Continued From page 18 Findings include: R10 is a 79 year old resident who was admitted to the facility on 11/20/06 with diagnoses including "Altered Mental Status and Dementia." R10 was admitted to the facility 3 days prior to R10 sexually assaulting R11. Record review of the facility's abuse files included an incident summary dated 11/23/06 at 1:00AM indicated documentation as follows: "R10 found naked in room with patient (R11) in room 340 bed 1. R10 was kneeling down with R11's penis in R10's hand climbing into bed with the male resident. R10 had pulled R11's underwear down. R10 became agitated when approached. R10 threatened staff and writer states, 'I'm going to kill you, I will f---- you up.'" Review of R10's clinical record indicated nurses notes dated 11/23/06 at 1:00AM as follows: "R10 found in room 340 with R11. R10 was naked kneeling down with R11's penis in his hand. R10 was observed climbing into bed with R11 while attempting to remove R11's underwear when discovered R10 became very agitated and threatened writer. R10 states 'I'm going to kill you", I will f--- you up.' R10 was redirected to chair by nurse station by writer to monitor R10 1:1." Clinical record review indicated that R10 was sent to a local hospital for a psych eval on 11/23/06 at 2:10AM but R10 returned to the facility approximately 3 1/2 hours later, on 11/23/06 at 5:30AM. Nurses' notes dated 11/23/06 at 2:45PM state:	F9999		

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F9999	Continued From page 19 "R10 continues to ambulate down hallway." Nurses' notes dated 11/24/06 included documentation for R10 as follows: "R10 up ambulatory around unit continues to wander in and out of rooms and doors on unit. R10 remain agitated". Surveyor did not note any documented 1:1 monitoring at this time even though R10 had this sexual encounter with another resident less that 24 hours earlier. On 12/03/06 at approximately 3:25PM, E1 (administrator) brought E4 and E5 (both nurses) to the conference room to talk to surveyor regarding R10 receiving 1:1 monitoring upon R10's return to the facility. E4 stated, "I started 1:1 on R10 on 11/24/06 and it continued until I left at 3:30PM". E4 was further interviewed regarding R10 continuing to receive 1:1 monitoring throughout the evening. E4 stated, "I don't know what happened after I left." E5 was later interviewed. E5 stated, "R10 was assigned a 1:1 during the 7:00 to 3:00 shift and they wanted me to continue this until R10 was picked up by ambulance, I assigned a CNA ." Surveyor questioned E5 as to who informed her of R10 being on 1:1 and who asked her to continue it. E5 stated, "E4 asked me to continue the 1:1." This interview with E5 is in conflict with E4's earlier interview when E4 told surveyor "I don't know what happened after I left." (in response to question by surveyor regarding continuation of 1:1 for R10) Upon further interview neither E4 nor E5 could provide documentation of 1:1 monitoring for R10. Neither E4 nor E5 could provide an explanation as how	F9999		

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F9999	Continued From page 20 R10 continued to wander in and out of residents' rooms on 11/24/06 if there was 1:1 monitoring. On 11/30/06 at approximately 3:20PM, R10 and R11 were both observed in the same activity group on the 3rd floor of the facility. During daily status on this day at approximately 4:40PM, E1, E2 and E3 (Director of Nurses) were interviewed regarding separation of R10 from R11 especially since R10 continues to wander in and out of residents' rooms. E1 stated that R10 receives 1:1 monitoring now and that R10 and R11 are both cognitively impaired. E3 added, "I just spoke with our psychiatrist who is here in the building, and he (psychiatrist) said that a lot of dementia residents are hypersexual and R10's behavior may continue on another floor." Surveyor continued to interview E1, E2 and E3 with regard to supervision of R10. E1 added "R10 was supervised," however upon further interview E1 could not provide evidence of monitoring R10 by the facility staff. On the next day of the survey (12/04/06) R10 was observed moved to another floor in another room with a sitter present. (R10 was moved 7 days after R10 had sexually assaulted R11 and after prompting by surveyor). On 12/06/06 at approximately 9:05AM in the 1st floor conference/exam room surveyor interviewed E10 (nurse on duty who found R10 in sexual encounter on 11/23/06) regarding what he observed on the night R11 was assaulted by R10. During this interview E10 described what he had observed on the night of this incident exactly as	F9999		

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F9999	Continued From page 21	F9999		

he had documented it in his nurses' notes and on the incident summary. E10 added that R10 has wandered up and down the hallways and in and out of residents's rooms since R10's admission on 11/20/06 and R10 was not easily redirected.

Upon further interview E10 stated, "At the time of R10 going into R11's room I was on the phone trying to get a hold of Z1 because R10 had been up all night, agitated and wouldn't settle down. The 3 CNAs' that night were busy with changing our heavy wetters and watching other wandering residents including R12 who is blind and also a wanderer. There was no special monitoring done for R10 until after this incident. I then assigned a CNA (certified nurse assistant) for 1:1 for R10, even though this was hard with only 3-4 CNA's and 76 - 78 residents." E10 further added, "R10 was still hard to manage even on 1:1 monitoring." Upon further interview E10 added, "I can't say if 1:1 continues once I leave in the morning or not." E10 finally stated, "I'm not sure I can say that any resident on the 3rd floor is safe because of the wanderers who need constant supervision and only 3-4 CNAs' with 76 - 78 residents. It gets overwhelming at times."

On 12/04/06 at approximately 12:30PM, Z1 was interviewed by surveyor (per phone) about receiving calls from the facility regarding R10's behavior including wandering and sexual encounter. Z1 stated, "I've gotten a lot of calls from the facility regarding R10 and I did get a call 11/23/06 after R10 returned from a psych eval at the hospital." Upon further interview, Z1 continued to say, "I don't remember. I get so many calls, but I have gotten at least another call since R10 came back from his psyche evaluation. I agree that something should be done by the

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F9999	Continued From page 22 facility about R10." The facility had knowledge of R10's wandering, going in and out of other residents' rooms, but neglected to know where R10 was at all times. This neglect put all residents on the 3rd floor at risk and had negative consequences for R11. On 12/20/06, the facility's "Abuse, Mistreatment, Neglect, Misappropriation of Property Policy and Procedure," revised 7/99 was reviewed. This policy defines "Sexual Abuse -- Includes but not limited to sexual harassment, sexual coercion or sexual assault." This policy also requires under section 9, "When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that another resident of the facility is a perpetrator of the abuse, the resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of the resident as well as the safety of other residents and employees of the facility." (A)	F9999		