STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	**4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008**

(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 224	Continued From page 15 the patient when behaviors are exhibited. The tool has been moved to the CNA data book on all units. Unit staff have been in serviced on the tool and the process. 9. The QA held a meeting on November 28, 2006, to review this incident, education provided, IDT and department head responsibility for identifying, reporting, and monitoring patient behavior. 10. The social service director will report to the QA with corrective action. Completion Date November 28, 2006.	F 224		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.1210a) 300.3240a)f) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

(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
F9999	Continued From page 16 resident. (A, B) (Section 2-107 of the Act) 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 REGULATIONS are not met as evidenced by: Based on interviews and record reviews, the facility failed to implement policies and procedures to protect one resident in the sample (R1) from being sexually assaulted by another resident (R2) with a history of inappropriate sexual behavior. This failure resulted in R1 needing treatment in the Emergency Room, suffering emotional harm and trauma related to the incident. Findings include the following: According to interviews with staff on duty, R1 was noted to be screaming and calling for help in the TV lounge on 11/18/06. E8 (Nurse Aide) heard screaming as she passed the lounge and noted the door was closed. According to E8, that door is always open and E5 (Nurse Aide) called out that the door was locked. E8 stated during interview of 11-22-06 that she heard R2 say "shut up" as she knocked on the door. When the door opened, R2 was noted pulling up his	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

(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
F9999	Continued From page 17	F9999		

suspenders and his zipper was open on his pants. E8 stated that R1 was naked with "pants down to her knees and no bra or shirt on." E8 stated that R1 was screaming and told her that R2 took off her clothes and put his fingers "inside". (Meaning inside her vagina). E8 stated "Something happened! R1 is dependent for care and cannot dress herself."

E5 was interviewed on November 21, 2006, and stated that it was about 12:15pm, and he heard noises from the TV lounge. The door was locked, and he heard someone yelling "no, no leave me alone." E5 stated at first he did not know who it was, but he knew something was wrong since the door to the lounge is always open. E5 stated that E8 was there when R2 finally opened the door and was pulling up his suspenders. R1 was crying and screaming. E5 stated that R1 indicated that R2 "put his fingers in me." E5 also stated that R1 was without clothes on top and her pants were down around her knees. E5 stated that when E12 (Nurse) and E13 (Nurse) arrived, he left the room to let the female staff care for the resident.

E4 (Nurse Aide) was interviewed about the incident on November 22, 2006. E4 stated that he was in the hallway and his co-workers (E5 and E8) were yelling for him. E4 indicated that both E8 and E5 were trying to get into the lounge but the door was closed and locked. E4 stated that when the door opened, R2 came out and was fixing his suspenders, and R1 was with her pants down. E4 stated that he never knew that the door could be locked, and it was always open.

E6 (Nurse Aide) was interviewed on November 21, 2006, about the incident and reported seeing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

(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
F9999	Continued From page 18	F9999		

R1 with her pants down and heard the resident state that R2, "he got me, my breasts." E6 stated the incident occurred about 12:15 pm on November 18, 2006.

E13 (Nurse) was interviewed on November 22, 2006. According to E13, E8 was calling her to come and because of E8's tone, E13 was concerned. E13 stated at first she thought a resident had fallen. But when she entered the TV lounge, R1 was noted with her pants down and clothing around her neck. R1 told her that R2 took off her clothes and "he touched my private parts and breasts." E13 stated that R1 cried on and off and that she went to call E1 (administrator), E4 (manager on weekend duty), and the physician. E13 stated that she did not call the police or law enforcement. E1 called R1's family members. E12 (Nurse) was also on duty November 18, 2006, and was also called by staff to the scene. E12 verified that R1 was with her clothing around her knees and her top off. E12 also stated that the police were not called.

E4 (manager on weekend duty) was interviewed by surveyor on November 21, 2006, and stated that she attempted to make sure the residents were safe and then she called E1 for further direction. E4 stated the police were not notified of the incident. E4 stated she stayed until both residents were discharged to the hospital.

R1 was discharged to the Emergency Room (ER) at 3:00 pm and returned later that evening at 8:15pm to the facility. R1's family members (Z2 and Z6) were present at the ER with R1. Both Z2 and Z6 were very concerned about R1's welfare after the incident due to the resident's psychological history. Z6 stated to surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	**4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008**

(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
F9999	Continued From page 19 during interview of November 21, 2006, "I have never seen my sister cry so much..." Z2 also stated she was very concerned about the well being of her family member after the incident. R2 was also discharged back to the facility since the hospital would not admit the resident. E3 (Director of Nursing) placed R2 under one to one monitoring on a separate floor from R1 until he was finally discharged to a Psychiatric facility at 10:30 pm. According to E1, the facility has issued R2 a discharge notice. During the survey, R1 was noted by staff to have emotional issues related to the incident. Staff noted R1 to be withdrawn and afraid to be alone. Z6 and Z2 also stated that their family member was very upset. The Psychiatric Nurse did see R1 on November 20, 2006, and noted that R1 "did not want to discuss the incident." Z6 stated to surveyor "you have to let her tell you about it in her own way and time." E11 (Social Worker) charted on November 20, 2006: "does not want to sit at her table since the male resident sat there." Nursing Notes dated November 20, 2006 state, "resident crying on and off today, refused breakfast didn't want to go to the dining room for stated that she was scared." A review of R1's medical record indicates that R1 is dependent upon staff for transfer and dressing. R1 is unable to dress herself or remove clothing from the upper torso. R1 is a 71 year old female with the following diagnoses: Diabetes, Hypertension, Bipolar Disorder, Depression, Mild Mental Retardation, and Renal Failure. R1's MDS (Minimum Data Set) Assessment dated 10-31-06, R1 is coded to need extensive assistance with dressing and transfer. Staff interviewed and surveyor observations of the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

(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
F9999	Continued From page 20	F9999		

resident concur that it would be impossible for R1 to remove her shirt and or pants as found on the day of the incident.

A review of R2's record indicates that R2 is 62 year old male with the following diagnoses: Diabetes, Hypertension, Constipation, Vascular Dementia, and Morbid Obesity. R2's MDS dated 10/3/06 codes R2 as being totally independent in walking and transferring. R2 is coded to need set up for dressing and one person assist for bathing. In addition, the MDS codes R2 as having behavioral symptoms that occurred daily and that were not easily re-directed in the area of socially inappropriate behaviors and resisting care.

A review of R2's record also revealed that on September 14, 2006, R2 was noted to touch another female's breast (R3) in the same TV lounge that the November 18th incident occurred. E11 interviewed R2 and R2 admitted to touching the female's breast and was counseled. R3 has expired since the incident. E11 developed a care plan for monitoring R2 and stated during interview of November 22, 2006, that staff on the unit were aware of the incident and they would, "monitor R2." E11 stated that R3 was embarrassed about the incident and did not want R2 to get into trouble. E11 stated that the Psychiatric Nurse visited R2 after the incident and prescribed Depakote. E11 stated that staff should have been aware of the first incident.

Interviews with nursing staff on duty November 18, 2006, indicate that E13, E12, E6, E9, E5 were not aware of any previous incidents regarding R2. In fact, the majority of the staff on the unit that day did not know of the care plan regarding R2's behavior. E8 stated that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. BUILDING _____ B. WING _____	C 11/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ROLLING MEADOWS	**4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008**

(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
F9999	Continued From page 21 knew of another incident but did not remember when it happened. E8 also stated, "he walked in and out of the building. He went all over the place. What is he doing here?" E5 stated about R2, "you cannot tell him what to do; he just gets upset." E6 stated, "R2 would get upset with you if you just ask him to take a shower; he is always saying things to the female staff." E9 stated, "R2's behavior is unpredictable; we just don't know why or what is in his mind." The facility failed to implement a care plan and monitoring system for a resident with a history of being sexually inappropriate. The facility failed to prevent R1 from being abused by a fellow resident by not monitoring R2's behavior and implementing a formulated plan of care. And the facility failed to notify law enforcement of an alleged sexual assault. The facility failed to follow their own policy on preventing abuse by: 1. Not adequately training staff on methods for dealing with aggressive and patient reactions. 2. Not preventing abuse by not monitoring a resident with known behavior problems. 3. Failing to notify local law enforcement of a potential abuse. (A) 300.695a)1)2)3) 300.695b)3) Section 300.695 Contacting Local Law Enforcement	F9999		