| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145771 | A. BUILDING _____ B. WING _____ | C 11/29/2006 |

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| **RIVER BLUFF NURSING HOME** | **4401 NORTH MAIN STREET ROCKFORD, IL 61103** |

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| F 498 | Continued From page 26<br>have anything in place to monitor the staff performance when using the lift". | F 498 | | |
| F9999 | FINAL OBSERVATIONS<br><br>Licensure Violations<br><br>300.1210a)<br>300.1210b)6)<br>300.1220b)2)<br>300.3240a)f)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.<br><br>Section 300.1220 Supervision of Nursing Services<br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>2) Overseeing the comprehensive assessment of | F9999 | | |

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| F9999 | Continued From page 27<br>the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br>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.<br><br>These requirements were not met as evidenced by the following:<br><br>Based on observation, interview and record review, the facility neglected to initiate 1:1 monitoring of R3, neglected to develop a 1:1 monitoring policy, and neglected to develop a Resident on Resident abuse policy. The facility also neglected to identify the cause of R3's sexually inappropriate behavior change and did not monitor R3's whereabouts after staff were made aware of the first incident on 10/30/2006. The facility also failed to conduct a thorough investigation of an incident of inappropriate sexual behavior by R3 involving 4 female | F9999 | | |

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| F9999 | Continued From page 28<br>residents(R1, R2, R9, & R10). Staff were made aware of the first incident on 10/30/06 at 5:15PM and the second incident on 10/30/06 at 7:30 PM. These failures resulted in R3 fondling the breasts of R1, placing his hands inside the blouse of R2, attempted to touch R9 &R10( female residents) inside their blouse, at the collar bone, on 11/10/06, and kissing females stating that they are his wife. These areas of neglect apply to five residents, including one aggressor (R3) and 4 victims (R1,2,9, & 10).<br><br>Findings include:<br><br>R3 is a 91 year old male resident with diagnoses including Hypertrophy Prostate with Obstruction, Cataracts, Chronic Airway Obstruction, Malaise and Fatigue, Weight Loss, and Mild Memory Loss (Dementia), according to his 11/06 Physician Order Sheet (POS). According to his POS his medications include Haldol (anti-psychotic) 1 milligram (mg) Intramuscular or by mouth every 12 hours as needed for increased agitation, and Ativan (anti-anxiety) 0.5mg at bedtime. On 10/30/06, according to his 10/06 POS, the Ativan was increased to 1mg every evening for agitation.<br><br>According to R3's Minimum Data Set of 10/24/06, he is moderately impaired in daily decision making. Nursing Notes show R3 began exhibiting behaviors on 10/30/06 at 5:15PM. R3 was in the unit dining room touching females, and kissing them saying that they were his wife. According to the Nursing Notes, at 5:15PM staff, "tried to offer him dinner but wants to kiss the females. Combative when trying to redirect him." At 6:30PM, R3 was "seen by staff with his hand down a female's blouse (R2- according to her | F9999 | | |

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| F9999 | Continued From page 29<br>8/8/06 MDS, has severe cognitive impairment) on Hall III - unit dining room. Unable to redirect. Became combative, verbally abusive to staff...assisted to room, would not stay, pacing hallways." At 7:55PM Nurses Notes state "Certified Nursing Assistant (CNA) found this resident (R3) in a room fondling female resident (R1) in bed 1. Redirected and taken to his room...."<br><br>Review of the facility's report of the 10/30/06 incident shows that none of the residents residing on the unit were interviewed to determine if R3 had been sexually inappropriate with any other residents.<br><br>On 11/8/06 at 12:00 Noon, E10 (Clerical Specialist) said that when R3 wants something "there is no stopping him. This morning I saw him kissing R10 on the top of her head. She told him to stop." On 11/9/06 at 12:10PM, R1 said that she could recall the incident on 10/30/06. R1 said that she was asleep in her bed. When she woke up a man had his hands under her gown. R1 said "I was upset-I called my daughter."<br><br>On 11/9/06 at 2:50 PM E3 (Dove Unit Manager) said that R3 was moved to another room in an attempt to protect the female residents from R3's behaviors. E3 said that the III hall is predominately male residents. Review of the facility's bed list shows that as of 11/08/06 there are 5 female residents on the same hall where R3 resides. E3 said that the staff are monitoring his whereabouts and all staff are aware of the behaviors he has been displaying. She said that the unit staff cannot provide 1:1 monitoring of R3, and that one of the interventions put into place to protect the other female residents on the unit is | F9999 | | |

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| F9999 | Continued From page 30<br>that he is not to be placed at a table with female residents. On 11/9/06 at 12:10 PM R3 was observed seated next to a female resident in the unit dining room.<br><br>On 11/9/06 at 12:15 PM, R3 was observed in another resident's room which is one door down and across the hall from R3's room. There are 2 female residents residing in that room. According to E9 (Registered Nurse) a 1:1 flow sheet was implemented on 11/8/06. The staff are to document, by placing their initials on the flow sheet every 30 minutes, showing that they know R3's whereabouts. There is no one staff member in charge of him. All of the staff know that they are to be watching him.<br><br>The facility's abuse policy dated 7/16/01, states its purpose is "to provide an environment free of verbal, sexual, physical and mental abuse to the facility residents." The policy statement reads, "It is the policy of River Bluff Nursing Home to not tolerate abuse or neglect of its resident by any individual, including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to a resident, family members, legal agents and/or friends." The policy defines sexual abuse as "...harassment, coercion, assault, penetration and/or conduct." Number 4 letter f of the policy, titled Identifying, Reporting and Investigating Possible Occurrences of Abuse/Neglect Incidents, states "Protect the resident(s) during the investigation process...Residents who allegedly mistreat another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, | F9999 | | |

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| F9999 | Continued From page 31<br>care approaches and placement, considering his/her safety, as well as the safety of other residents and staff." The facility staff did not follow this policy and did not remove R3 to prevent continued inappropriate touching of female residents.<br><br>On 11/9/06 at 1:30 PM, E2 (Director of Nursing) said that if 1:1 monitoring was done with R3 his behaviors would escalate. E2 also said that there is no facility policy regarding 1:1 monitoring of residents. E2 also said no abuse risk assessments for any of the residents residing at the facility have been done to determine which residents are at risk for abuse.<br><br>R3's Care Plan dated 10/30/06 lists Sexual Inappropriateness as a problem. The Two approaches on the Care Plan were to seat the resident with other male residents and redirect from female residents.<br><br>A facility incident report shows that, on 11/10/06 at 2:35 PM, R3 again displayed inappropriate sexual actions towards female residents. R3 "attempted to touch a female resident (R10) inappropriately. Staff intervened and redirected him away. He then went to another female resident (R9) and attempted the same thing. He was again redirected away per staff." Nursing Notes dated 11/10/06 at 2:30PM state, "CNA notified nurse that she saw this resident (R3) touching the breasts of a female resident (R10). CNA took female resident to another area of the unit and went to redirect another female resident from going outside in the rain. When she came back this resident (R3) had his hands on another female resident's (R9)breasts...." | F9999 | | |

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| F9999 | Continued From page 32 (A) | F9999 | | |