STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 323	Continued From page 24 updated regarding sexual expression for R1, R2, R6, R7 and R8 will be completed by 9/6/07 at 4:30 pm. 5. 9/5/07 - Chart audit of all residents on Alzheimer's unit will be completed by 9/6/07 at 4:30 pm. 6. 9/5/07 - Interviews of all staff who have worked on the Alzheimer's unit during 7/1/07 - present will be completed by 9/7/07 at 4:30 pm.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 300.1220b)2) 300.1220b)3) 300.1220b8) 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:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

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F9999	Continued From page 25 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 26	F9999		

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

Section 300.3240 Abuse and Neglect
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.
These requirements are not met as evidenced by:

Based on record reviews, interviews and observations the facility:

1) Failed to identify and evaluate the sexual behaviors of residents with known moderate to severe impaired cognition levels for understanding of these behaviors.
2) Failed to document the sexual behaviors as they occurred.
3) Failed to develop a plan of care prior to the sexual activity addressing residents' needs.
4) Failed to implement interventions.
5) Failed to ensure that all residents were provided with adequate supervision for 8 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 27	F9999		

confused residents.

Findings include:

1) E8 (Certified Nursing Assistant/CNA) was interviewed on 8/29/07 at 9:45 am and stated, "On 8/18/07 I was the one to witness their incident (R6/R7). I was taking (another resident) to bed around 1:45 pm. I was laying (R12) down and I heard 's*** it - just s*** it.' (R12's) room connects to (R13/R14's) room so I went into (R13/R14's) room. That is when I saw (R6) was standing over (R7) and she was s***ing his penis. I said 'What's going on?' (R6) said 'she is helping me pull my pants up.' I didn't think it should be happening. When I left the room his pants were up and he was in the doorway (of the room). I flew down the hall and yelled for (E7/CNA). When we got back, (R6) was taking his pants down again and saying 's*** it' to (R7). (R7) was just sitting on the bed - she was just babbling like she always does. When (E7) and I got back to the room, (R7) was holding (R6's) penis and he was rubbing her breasts on the outside of her clothes. When we got to the desk, (R6) asked (R7) if she wanted to f***. (R7) said 'I ain't paying for no hotel.'" E8 then further stated, "I don't think it should be ok. (R7) really can't tell us anything. (R6), if he wants something, he asks for it. I told (E19/LPN)."

Through interviews with other staff it was determined there were three incidents of sexual behaviors involving R6 and R7.

E7 (CNA) was interviewed on 8/29/07 at 8:57 am and stated, "It was 8/18/07. It was after lunch break. I heard (E8) call she needed help right away (down the women's hall). I went down and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 28	F9999		

(E8) was walking (another resident) to her room because (other resident) was trying to get in the room (R6) and (R7) were in. When I walked in, (R7) was sitting in bed and (R6) was standing up by the bed with his pants halfway down. I didn't see her face or body part but (R6) was saying 's*** it.' We asked (R6) to leave the room - he is very alert and then we brought (R7) up to the nurse's desk. (R6) came up to (R7) and said 'Do you want to f***?' (R7) said she was not paying for a hotel. You cannot hold a conversation with (R7). She would not be able to consensually say yes. She (E1/former Administrator) said since they didn't have a guardian we should have let them go and if it happened again we can't stop it. (E1) said the Power of Attorney (POA) was not to be involved, only if they have a guardian. (E19/LPN) was coming down the hall and she knew. (E1) interviewed (staff) the beginning of the week (8/20/07)."

E11 (CNA) was interviewed on 8/29/07 at 2:52 pm and stated, "I think it was Monday 8/27/07. I walked in on them the second time (during oral sex). (R7) was in bed and (R6) had his penis in her mouth. I asked what he was doing. He said 'what are you talking about.' The first time I wasn't there but was told it was oral sex again. (R7) just kind of chatters. When you ask her to do something she does it - right or wrong. I don't think she knows the difference. I told the nurse. I also worked third shift that night and (R6) kept trying to go down the women's hall."

E3 (LPN/Licensed Practical Nurse) was interviewed 8/29/07 at 10:20 am and stated, "I was not here but (was told) it happened close to shift change. On Monday (8/20/07) nothing was charted about it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 29	F9999		

E12 (Alzheimer's coordinator) was interviewed on 8/29/07 at 2:05 pm and stated," A staff member found them (R6/R7) engaging in sexual activity. Family/doctor are aware. Our Social Service consultant (E18) is explaining to us if two residents are on the same cognitive level then it's ok. If you were to ask (R7) if she wanted to have sex with (R6) I am not sure she would answer appropriately. I am not quite sure how (R6) would answer. Staff were instructed to monitor the activities and be sure each time is consensual."

The admission face sheet for R7 - the first female resident involved in sexual behaviors with R6, dated 12/14/06 shows diagnoses including: Psychosis not otherwise specified, and Alzheimer's disease and lists Z4 (spouse) as Power of Attorney for Healthcare.

Z6 (staff at physicians office) stated on 9/14/07 at 9:24 am, "(R7) has been a patient of (Z5's/physician) since April 2002 with a diagnosis of dementia. The official diagnosis of Alzheimer's was made 12/2006."

Nursing note dated 8/21/07 at 9:10 am states "(Z5-physician) notified that resident has entered into a sexual relationship with another resident. Both residents being monitored that it is a consentous (sp) relationship."

Z5 (Physician) was interviewed on 9/14/07 at 9:17 am and stated, "No, no one told me (about sexual relationship between R6/R7). They (facility) sent something to the office so when I made next rounds, I asked what was going on with them (R6/R7). Nobody was able to tell me anything about what happened. No one has given me any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 30	F9999		

details yet. No one said oral sex. The other day I got a message from the social services wanting to know about having a room for the patients (to have sex). I said no-I don't think the people on the Alzheimers unit could agree. I don't think they have the cognitive sense to make an informed consent - they have no cognition. They don't understand - especially (R7) - she has no cognition at all. They have to have the cognition to understand what they are doing. I would not consent to that. It can be avoided from happening once they (facility staff) knew about it. I would be able to examine and document once I know what is going on. I still don't know details."

E2 (Administrator/DON) provided documentation stating R7 was admitted to the Alzheimers unit on 3/28/02 and has remained on that unit since admission.

The current assessment dated 6/7/07 shows R7 as experiencing short-term and long-term memory deficits, oriented to staff names/faces only and severely impaired cognitive skills for daily decision-making (never/rarely makes decisions). The assessment notes R7 is usually understood (difficulty finding words or finishing thoughts) and sometimes understands (responds adequately to simple, direct communication) with clear speech. The assessment shows R7 displays the following behaviors on a daily basis: Verbally abusive behaviors (others were threatened, screamed at, cursed at); and Resists Care (resisted taking medications/injections, Activities of Daily Living (ADL) assistance, or eating). The following behaviors in the assessment are shown exhibited 4-6 times a week: Physically abusive (others were hit, shoved, scratched, sexually abused); and Socially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 31	F9999		

Inappropriate/Disruptive Behavioral Symptoms (makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared food, hoarding rummaging through other's belongings). R7's condition is described as: Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating).

R7 was interviewed on 9/4/07 at 9:05 am. R7 was unable to state her name. She stated she was 17 years old "look at all the kids" and was currently at home. R7 was unable to state where home was. R7 then made statements about "school in the trees," "Hansel and Gretel," and "books at the park." When asked if she had a boyfriend here she stated, "No boyfriend - my parents said no." R7 was unable to give any further relevant information and began talking in clear voice but nonsensical conversation.

On 8/22/07, nursing notes at 11:15 am note, "POA (Z2/son) notified of resident's relationship with male resident."

Z2 (son) was interviewed on 8/31/07 at 10:28 am and stated, "They (facility) told me she had become intimate with a male resident. The facility did not tell me what sexual acts they were doing."

Additional nursing notes in R7's medical record contained no entries regarding the sexual behaviors between these two residents. The care plan for R7 has no information regarding any sexual activity. The records contained no assessments of the residents in regard to their sexual activity before it started.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 32	F9999		

On 8/29/07 at 1:40 pm E2 confirmed she found no other nursing notes documenting the relationship between R6 and R7 and the care plan for R7 contained no information regarding any sexual behaviors.

On 9/4/07 the facility sent a care plan for R7 dated (8/21/07) identical to the care plan for R6). E10 (Care Plan Coordinator) was interviewed on 9/10/07 at 10:30 am and questioned regarding this care plan, and surveyor inquired where this care plan was since it was not noted on R7's care plan on 8/29/07, 8/30/07 and 9/4/07. E10 stated, "I retyped R6's care plan on 9/4/07 and wrote what had been done and the dates it had been done. I didn't write it on there until 9/4/07. R7's care plan should have been there because I wrote it the same day. I didn't retype hers but added the additional handwritten notes on 9/4/07. I keep the original in my office and put a copy on the unit. I need to check and put the new ones in the care plan book. The care plans were done 8/21/07 (fourth day after the first incident of sexual activity between R6/R7)."

The admission face sheet for R6 - the male resident involved with R7, dated 5/9/07, lists diagnoses including: Dementia and Depressive disorder. The face sheet lists a spouse who lives in the community. E2 (DON/Administrator) verbally identified Z4 (spouse) as Power of Attorney for R6 on 8/30/07.

Z6 (staff at physician's office) stated on 9/14/07 at 9:24 am, "(R6 has been a patient of (Z5) since 7/2007 and had Alzheimers diagnosis then."

On 8/21/07 at 9:10 am nursing notes states, "(Z5/physician) notified that resident has entered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 33	F9999		

into a sexual relationship with another resident. Both residents being monitored that it is a consentous (sp) relationship."

Z7 (Physician) stated in interview on 9/14/07 at 9:45 am,"(R6) was first diagnosed with Alzheimers on June 29, 2005. His Alzheimers dementia has increased rapidly since then. He was started on Aricept in June 2005. In October 2005 I added Namenda. He went downhill rapidly. I don't think he could make any decisions like that (sexual relationship) even on a good day. He has what...tried to be with 3 women? No he isn't capable of decision making - he just doesn't have the cognitive skills."

E2 (Administrator/DON) provided documentation showing R6 was admitted to the Alzheimers unit of the facility on 7/6/07 and resided there until 8/29/07.

The current assessment for R6 dated 7/15/07 notes R6 as experiencing short-term and long-term memory deficits with moderately impaired cognitive skills for daily decision-making (decisions poor; cues/supervision required). The assessment shows R6 is usually understood (difficulty finding words or finishing thoughts), sometimes understands (responds adequately to simple, direct communication) with clear speech and oriented to the season and his room. The assessment shows R6 does not display any behavior problems.

A care plan for R6 (undated) with next evaluation date of 11/21/07 was located in a binder on the Alzheimers unit although R6 had been moved to a different unit of the facility. This care plan identifies problem #1 as: Sexual expression with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 34	F9999		

the goal: The resident will exercise safe, respectful and appropriate practices thru 11/21/2007. The interventions listed are: 1) Meet with family to discuss their input regarding their resident's choices regarding sexual expression. 2) Monitor and keep safe. Staff is to intervene and redirect if and when either consenting adult shows S/S (signs and symptoms) of wanting to discontinue relationship. 3) Staff to monitor for any negative reactions such as pushing away, resident shaking head "No," saying "No," or cursing. 4) Staff to maintain privacy, discreetly closing a room door, drawing privacy curtain, yet continuing to monitor. 5) Staff is to treat residents with respect at all times.

R6 was interviewed on 8/30/07 at 8:12 am. R6 knew he lived in a nursing home but was unable to state the name of the facility where he lived. When the name was stated R6 responded, "It sounds familiar." R6 knew he was married and his spouse does not live here with him and stated,"She lives alone." R6 remembered his room had been changed but not why he was moved. R6 stated he has met many men and women while living here but "women are the least of my concern."

An investigation dated 8/19/07 completed by E1 (former Administrator) and E18 (corporate consultant) was provided by the facility on 8/29/07 and documents the following: E18 reviewed charts and listened to the staff interviews. E18 reviewed the Alzheimer's policy with E1 and E10 (Care Plan Coordinator) After E18 reviewed the policy with her home office, E1 then reviewed the policy with family and E22 (Corporate Consultant) and developed a care plan for sexual expression. The investigation does not give the date and time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 35	F9999		

of the interviews with staff and families and no signatures by staff or family are noted with these interviews. The investigation has no documentation of interviews with residents involved. According to the interviews by E1 and E10, family members were informed of the sexual nature of the incidents and consented to the relationship continuing.

E2 (DON/Administrator) was interviewed on 8/29/07 at 12:15 pm and stated, "They called me on Saturday night (8/18/07)...:..E20 (former admissions/Alzheimer coordinator) told me a little of what happened. She told me (R6) and (R7) were in a room - (R6's) pants were down and (R7) was fondling his penis. (R6) was telling (R7) to perform oral sex. I called and talked to (E1). She was aware of it, she knew they had been separated, they were watching them and she (E1) would investigate it. I called the CNA (E7) and talked to her on Sunday. She told me pretty much the same story. I do know (R7) fights when she doesn't want to do something. (E7) said (R7) was not fighting. E10 (Care Plan Coordinator) was with E1 during the investigation."

Z4 (spouse) was interviewed on 8/31/07 to discuss the intimate relationship between her spouse and R7. Z4 interrupted surveyor on the phone and stated, "Intimate? They (facility) never said anything about any intimate relationship. They told me he had 'kind of a relationship' with a woman on the unit. I knew who it was because I would see them holding hands. I said they (R6/R7) were probably like children - the holding hands. That was all I understood it (relationship) to be. I would not agree to him having an intimate relationship with anyone. I know if he was in his right mind he would not consent to that. There is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 36	F9999		

no way he could consent - really consent to anything now. I am very upset they (facility) did not tell me exactly what was happening. They (facility) also told me (R6) went into another woman's room but he is almost blind. I didn't think much of it. No, no, no, I would never consent to that (intimate relationship). When they (facility) told me he had his pants off one night I thought he was wet or hot. They (facility) didn't say anything more. They didn't talk to me about safe sex. They didn't say sex at all. They (facility) said they didn't think anything of the relationship. Why would I go along with them allowing him to have an intimate relationship? We have been married almost 59 years."

The facility's policy titled "Facility Policy: Sexual Expression in Residents with Dementia or Alzheimer's Disease" (undated) was received on 8/29/07, was reviewed and states:
POLICY: ....When residents with dementia or Alzheimer's disease pair up and express their sexuality by engaging in intimate and/or sexual behavior with another resident with dementia or Alzheimer's disease, the facility has an obligation to the residents involved, their designated responsible parties, and the staff.
PROCEDURE:
1) The staff shall document observations of residents engaging in intimacy and/or sexual expression and notify the social services staff (SSS) and the Director of Nursing (DON) as soon as possible or no later than 24 hours.
2) The SSS shall notify the designated responsible parties and interdisciplinary team, as soon as possible or no later than 24 hours of initial notification.
3) The SSS staff shall educate the designated responsible parties about the disease process

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 37	F9999		

and the residents' rights. a) Residents with decisional capacity have the right to seek out and engage in consensual intimacy and/or sexual expression; b) Residents with decisional capacity have a right to privacy, including private space for sexual expression; c) Residents whose ability to consent to sexual expression is questionable, have the right for their designated representative to be involved in decisions about their sexual expression.
4) Care plan meetings with designated responsible parties and the interdisciplinary team shall be scheduled as soon as possible or no later than 72 hours from initial notification of the social services staff.
a) The interdisciplinary team and designated responsible parties shall discuss the issues regarding the resident's intimacy and/or sexual expression. The following discussions may help this process: I. Determine if this relationship is carried out in ways consistent with each resident's past values. II. Determine if past values fully apply in the present context. III. Determine if these residents have the same rights to privacy and free association as other residents. IV. Determine to what extent others should be allowed to make decisions about these relationships. V. When one or both of he residents involved in a relationship has a spouse living in the community, determine if the new relationship is acceptable to their spouses, other family members, and staff. VI. Determine if both residents are capable of entering into the relationship without coercion.
b) The interdisciplinary team and designated responsible parties shall reach a consensus and develop plan of care to address the issues regarding intimacy and/or sexual expression.
8) The facility shall provide initial staff orientation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 38	F9999		

and ongoing staff training regarding intimacy and/or sexual expression as well as sensitivity awareness about residents' sexual rights and staff responsibilities.
9) The facility shall obtain consultation regarding intimacy and/or sexual expression in cases that are deemed complex or controversial.

E2 was interviewed on 8/29/07 at 12:15 pm and stated, "If they (residents) don't have a guardian it is their right to engage in sex."

Facility policy titled "Accident/Incident Reports," dated July 1998, was received from the E2 on 9/4/07. The portion titled "Standard" states:

The Accident/Incident Report is completed for all unexplained bruises or abrasions; all accidents or incident where there is injury; allegations of theft and abuse registered by residents, visitors or others; and resident-to-resident altercations.

Under "POLICY" it states:
Licensed personnel are responsible for the initiation and completion of the Accident/Incident report.

This facility policy defines Accident/Incident as:
An incident is defined as any happening, not consistent with the routine operation of the long-term care facility, that does not result in bodily injury or property damage; an incident report must be completed for each resident involved.

The portion titled "PROCEDURE" notes:
Notify supervisor of accident/incident; documentation in the Clinical Notes should include an accurate description of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 39	F9999		

accident/incident; Observe resident closely for any change from normal habits that could be an indication that there is an injury not notificed or diagnosed during the initial assessment. The family and physician should be notified immediately; Update resident care plan.

E2 (DON/Administrator) was interviewed at 4:00 pm with E10 (Care Plan Coordinator). E10 stated, "We said (told families) we would monitor the situation. We don't have an assessment process to determine a residents' ability to consent to sex. We don't have an assessment process to determine the risk versus the benefits of sexual relationships for residents."

Through interviews and nursing notes documentation was found noting R6 was found with a second female resident (R8).

On 8/28/07 a "Late Entry" by E21 (Licensed Practical Nurse/LPN) was located in the nursing notes for R8. This entry does not give the date and time of the incident but notes "Resident was found in a room other than her room with a male resident. Resident was fully clothed and male resident was partially dressed. The male resident was removed and redirected to his room. The female resident was then redirected to her proper room. No complaints. Will continue to monitor."

E11 (CNA) was interviewed on 8/29/07 at 2:52 pm and stated, "I was the one that walked in. I was in (R12's) room and heard someone saying no, no. I went to the room. (R8) was in bed - (R6) was hovering over her with his pants and depends down. It was like he was going to get in bed with her. I asked (R6) what was going on. He acted like he didn't know. The nurse (E21)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 40	F9999		

came and got (R6) dressed and out. I had redirected (R6) out of that hall before. (R8) was kind of scared. She kept thanking me for saving her."

E21 (Licensed Practical Nurse/LPN) was interviewed on 9/6/07 at 12:18 pm and stated, "I think it happened 8/31/07. I am not sure. What I saw, nothing happened. We got there before anything did. (R8) was fully dressed on one side of the bed - the closest to the door. When I saw (R6) his depends were on and his sweatpants were off. I told him he couldn't be in that room or in that hall. He knows that. He said 'Don't lecture, I know' when I told him (R8) wasn't able to really know what he was doing or (what he) wanted from her. I told the CNA (E11) not to let everyone in the facility know - the rumors tend to grow and spread. I thought it was something that needed to be kept on the unit. I didn't call anyone because nothing happened. Now, I would call and let someone know. I talked to (E22/corporate nurse) and I see why I should have called."

E2 (DON/Administrator) was interviewed on 8/29/07 at 1:00 pm regarding the incident between R6 and R8 and stated, "I talked to (Z3/family) on 8/27/07. (Z3) was not upset (about incident) but was upset no one called him. I didn't ask him if he wanted us to stop the activity. I would say it is a physical relationship rather than an emotional one. The date of the incident was 8/24/07. I found out 8/27/07. (Z3) called the facility because he had gotten an anonymous phone call."

The admission face sheet for R8 dated 7/21/06 lists diagnoses including: Psychosis not otherwise specified, Dementia with behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 41	F9999		

disturbance and Cerebral Vascular Accident (stroke). This face sheet lists her Power of Attorney as a family member.

The most recent assessment for R8 dated 8/13/07 identifies R8 with short-term and long-term memory deficits and moderately impaired cognitive skills for daily decision-making (decisions poor; cues/supervision required). R8 is described as confused to season, room staff and does not know she lives in a nursing home. Speech is noted as clear with R8 being understood as well as understanding others. This assessment shows R8 as having no behavioral problems. R8's condition is described as: Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating).

The care plan for R8 contains no information regarding sexual behaviors. The nursing notes contain no additional information regarding any sexual behaviors.

On 8/29/07 at 1:40 pm E2 confirmed she found no other nursing notes documenting the relationship between R6 and R8 (until the late entry) and the care plan for R8 contained no information regarding any sexual behaviors.

Z3 (grandson) of R8 was interviewed on 8/31/07 at 11:00 am and stated, "The facility called me about an incident that happened recently but there was no relationship. I was told it happened once. A guy took his pants down and was getting in bed with (R8) but they stopped it. They (facility) know I would not approve of a relationship. They know it's not ok with me but I do want to know if something like that happens and keep her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 42	F9999		

safe.....(R8) doesn't know who I am - only somebody she should know. The only one she remembers is her sister. She (R8) doesn't know what she is doing or saying - she couldn't give consent to a relationship with anyone and know what that meant. (R8) was a flirt in the 70's and 80's. Now she may flirt but would not know what she was actually doing."

Through interviews and nursing notes documentation R6 was found with a third female resident (R10) displaying sexual behaviors.

The nursing notes for R6 dated 8/26/07 at 1:55 pm note, "Resident was sitting at the table in the dining room by staff when CNA told me this resident (R6) was touching female resident. CNA got resident out of room. Will continue to monitor." The female resident was identified as R10 by E2 (DON/Administrator) on 9/5/07 at 3:24 pm.

The assessment dated 6/27/07 for R10 documents R10 experiences short-term and long-term memory deficits with moderately impaired cognitive skills for daily decision-making (decisions poor; cues/supervision needed). The assessment shows R10 is usually understood (difficulty finding words or finishing thoughts), usually understands (may miss some part/intent of message) with clear speech. R10 is noted with the following behavior: Resists Care (rested taking medications/injections, Activities of Daily Living (ADL) assistance, or eating) 1-3 days of the last week. R10's condition is described as: Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 43	F9999		

E2 (DON/Administrator) was interviewed on 9/6/07 and stated one of the CNA's (Certified Nursing Assistant) (E23) on duty stated she saw R6 "touching" R10 and the other CNA on duty (E9) did not see anything. E2 was unable to define "touching" as it related to this incident.

E2 stated on 8/30/07 at 11:30 am "(R6) was moved to (a different wing of the facility) on 8/29/07 due to 'behaviors.'"

Staff on the new unit were interviewed on 8/30/07. E14 (CNA coordinator) was interviewed at 8:43 am regarding instructions given when R6 transferred to their unit and stated, "We were told to keep a close eye on (R6) so he doesn't wander into others rooms." When asked what "close eye" meant E14 stated, "Every 15 minutes." E14 stated a log of 15 minute checks was not kept. E14 also stated, "We are supposed to keep him out of the females' rooms as much as possible but we can't stop him all the time." When asked if she knew where R6 was at that time she stated, "He is in the dining room." E14 was informed R6 was currently in his room and a female resident had been delivering papers to the men in that hall alone.

E7 (CNA) was the other CNA on the unit where R6 had been transferred. E7 was interviewed on 8/30/07 at 8:56 am and was asked if she was knew where R6 was located and stated, "I have no idea."

E16 (Licensed Practical Nurse/LPN) was interviewed on 8/30/07 at 9:10 am and 9:17 am and stated an assignment sheet had not been filled out yet, and only two CNA's were on the floor that day to cover all three wings of the hall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 44	F9999		

(39 residents) including R6's room, so room numbers were not assigned as the CNA's had to work together. E16 also stated a third CNA came in to do whirlpool only at 8:00 am.

2. Through interviews and nursing notes two different residents (R1 and R2) were found by staff displaying sexual behaviors on two separate occasions, 8/1/07 and mid August (exact date unknown).

E15 (Certified Nursing Assistant/CNA) was interviewed on 8/30/07 at 11:42 am and stated, "I think it was 8/1/07. I was walking down the hall and got to (room). I saw (R2) behind (R1's) ambulation device with her shirt up. (R2) had (R1's) shirt about halfway off. One arm was out and about half her chest and back were exposed. (R2) was fully dressed. We (E15 and E17-unit assistant) took (R2) out. We told (E3-Licensed Practical Nurse/LPN)."

E3 (LPN) was interviewed on 8/29/07 at 10:20 am and stated, "I didn't see anything. The CNA's told me. It was the 17th or 20th (of August) I think. They told me (R2) almost got (R1's) shirt over her head. I told (E1/former administrator) and she said not to worry about it."

E7 (CNA) was interviewed on 8/29/07 at 8:57 am and stated, "I didn't see anything. I was on break but when I came back, the Unit Assistant (E17) told me she saw (R1) in her ambulation device with (R2) in a room down the hall and (R2) had (R1's) shirt up over here head. I don't remember when; mid August."

E2 (Director of Nursing/Administrator) was interviewed on 8/29/07 at 12:30 pm and stated, "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 45	F9999		

was informed by R1's daughter on 8/28/07.....We didn't know what she was talking about. She finally told us she had gotten an anonymous phone call that (R2) had been disrobing (R1). I explained I would start an investigation and get back to her."

The admission face sheet for R1 dated 1/4/07 list diagnoses including: Psychosis not otherwise specified and Alzheimer's. The medical record shows a daughter listed as court appointed guardian dated 4/5/2006.

The current assessment dated 4/2/07 documents R1 as experiencing short-term and long-term memory deficits with severely impaired cognitive skills for daily decision-making (never/rarely made decisions) and recalls staff names/faces only. The assessment notes R1 rarely/never understands, is sometimes understood with unclear speech. The assessment shows R1 displays the following behaviors on a daily basis; wanders (moves with no rational purpose, seemingly oblivious to needs or safety); Socially Inappropriate/Disruptive Behavioral Symptoms (makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared food, hoarding rummaging through other's belongings); and Resists Care (resisted taking medications/injections, Activities of Daily Living (ADL) assistance, or eating). R1's condition is described as: Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating).

R1 was observed on 8/29/07, 8/30/07 and 9/4/07 independently ambulating with the use of an ambulation device. Attempt to interview R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 46	F9999		

done on 9/4/07 at 9:00 am at the facility. R1's speech was unintelligible and rambling. Her attention span was brief and after several attempts to interview, the interview was terminated.

Z1 (daughter of R1) was interviewed on 8/30/07 at 7:30 am and stated she had received an anonymous call on 8/27/07 stating a male resident had "disrobed" R1. Z1 stated she still had not been informed of what had happened or when it had happened. Z1 also stated on or around 8/16/07, another family member went to visit R1 and when the family member went to leave, R1 kept saying "don't go, don't go" which Z1 characterized as unusual behavior for R1.

The nursing notes for R1 were reviewed 6/9/07 to 8/29/07 (date surveyor entered the facility). There is no documentation showing R1 had been disrobed by a male resident.

The facility failed to assess R1 after either incident to determine R1's ability to consent to this behavior and failed to notify the family of the incidents.

The care plan for R1 fails to identify approaches after the 8/1/07 incident and the mid-August incident for facility staff to utilize to monitor and protect R1 from further incidents of this behavior.

The face sheet for R2 dated 8/8/07 (readmission date) lists diagnoses including: Schizophrenia, Depression, Dementia, Agitation and Anxiety. The medical record shows a family member listed as "Temporary Guardian of Person" dated 12/2/2004. No permanent guardianship papers were located in the medical record or found by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 47	F9999		

(E2) Director of Nursing/Administrator.

The most recent assessment dated 7/1/07 documents R2 as experiencing short-term and long-term memory deficits, unable to recall the season, location of room, staff names/faces or that he resides in a nursing home. This assessment shows R2 having moderately impaired cognitive skills for daily decision-making (decisions poor, cues/supervision required) and notes R2 sometimes understands; is sometimes understood with unclear speech. The assessment documents R2 as experiencing the following behaviors on a daily basis; Wandering (moves with no rational purpose, seemingly oblivious to needs or safety; Verbally Abusive Behavioral Symptoms (others were threatened, screamed at, cursed at); Socially Inappropriate/Disruptive Behavioral Symptoms (makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared food, hoarding rummaging through other ' s belongings); Resists Care (rested taking medications/injections, Activities of Daily Living (ADL) assistance, or eating). R2's condition is described as: Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating).

R2 was observed on 8/29/07, 8/30/07 and 9/4/07 on the unit ambulating independently. R2 was interviewed on 8/30/07 at 8:05 am. R2 was able to state he had eaten and lifted his shirt to show his stomach. Speech was garbled and few words were intelligible. On 9/4/07, R2 was unable to answer direct questions regarding his name, where he lived or his age. When asked if he had a girlfriend or had sex - R2 only looked at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 48	F9999		

surveyor and continued with unclear speech.

The care plan fails to identify the 8/1/07 incident and the mid-August incident.

3. Through interviews and documentation, two additional residents (R9 and R11) were found by staff displaying sexual behaviors.

E2 was questioned regarding this incident on 8/30/07 at 8:30 am. E2 did not remember the male involved. The male resident was identified by E2 on 9/4/07 at 4:35 pm as R11.

R9's most recent Minimum Data Set dated 6/27/07 lists diagnoses including: Alzheimer's disease, Anxiety Disorder and Transient Ischemia Attacks. The MDS shows R9 experiences short-term and long-term memory deficits with moderately impaired cognition (decisions poor; cues/supervision needed). It describes R9 as usually understood (difficulty finding words), usually understanding (ay miss some part/intent of message with clear speech. R9's condition is described as: Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious or deteriorating).

R11's most recent assessment dated 7/25/07 identifies R11 as experiencing short-term memory loss and oriented to his room only with modified independence in cognitive skills for daily decision-making (some difficulty in new situations only). R11 is noted to be understood by other, understands others with clear speech. No behaviors are identified.

The nursing notes for R9 dated 7/30/07 by E3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145645	A. BUILDING _____ B. WING _____	C 09/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL HEALTH AND REHAB	4747 11TH STREET EAST MOLINE, IL 61244

(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 49 state "Resident was sitting in kitchen when a male resident tried to put hand up this resident shirt. Zero complaints by resident and no S/S (signs/symptoms) of distress at this time." (A)	F9999		