STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145446	A. BUILDING _____ B. WING _____	C 07/31/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIGOLD REHAB & HCC	275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401

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F 000	INITIAL COMMENTS Investigation of Complaints 0723028/IL29818-F223 0723202/IL30004-No Deficiencies A partially extended survey was conducted.	F 000		
F 223 SS=J	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by : Based on observation, record review and interview, facility failed to protect one female resident, R1, from 2 incidents of sexual abuse by R2, to assess the continued need for physical monitoring of R2, to record all sexually inappropriate behaviors for R2, and to implement the individualized approaches to monitor R2. This failure resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 7 /15/07 (when R2 was placed on one-on-ones), the facility remains out of compliance at severity level two. Additional time is needed to evaluate the implementation of revised policies and procedures and the effectiveness of these changes. Findings include:	F 223	Signature page	

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

8-17-07

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 223	Continued From page 7 p.m., and was completed 7/27/07 6. Facility will conduct continued and ongoing monitoring by reviewing all new behaviors or allegations of abuse with the Care Management Team on a weekly basis. Emergent or escalating behaviors will be dealt with immediately. 7. Any resident who is on 15-minute monitoring or one-on-one supervision will be reviewed by the Care Management Team within 72 hours of initiation, to determine if further monitoring, changes in monitoring or other interventions are needed. 8. Any ongoing monitoring will be reviewed weekly during the Care Management Meeting to either determine ongoing needs or removal of monitoring. 9. The Care Management Team will report to the Quality Assurance Committee for further review and recommendations monthly.	F 223		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1220b)2) 300.1220b)3) 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	F9999		

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F9999	Continued From page 8 personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. 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		

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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 observation, record review and interview, the facility failed to protect one female resident, R1, from 2 incidents of sexual abuse by R2, to assess the continued need for physical monitoring of R2, to record all sexually inappropriate behaviors for R2, and to implement the individualized approaches to monitor R2.

Findings include:

R2's Admission Record states that R2 (perpetrator) was admitted on 1/8/04 with senile dementia, anxiety state and depression, among other diagnoses. Physician Order Sheet dated 7/16/07 shows Parkinson's disease, OBS (organic brain syndrome) with behavioral disorder, among other diagnoses. The latest assessment, dated 4/23/07, outlines that R2's cognitive skills for daily decision making require supervision because of short and long term memory problems. The assessment also states that R2 needs "extensive assistance" of one person physically assisting him to walk in the corridor. Care Plan covering the period of 5/6/07 to 7/23/07 with respect to Psychotropic Drug Use

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outlines that resident was found in another resident's room displaying inappropriate behavior on 5/12/07. (The other resident was R1.) The intervention/approach section states that 15-minute checks were to be initiated for 72 hours after this inappropriate behavior.

According to the Admission Record, R1 (victim) was admitted on 12/7/04 with Alzheimers disease, delusional disorder and reactive psychosis, among other diagnoses. Assessment of 6/11/07 documents that resident is "moderately impaired" with respect to cognitive skills for daily decision making with both short and long term memory problems. R1 needs two persons physically assisting her for transfers and she does not walk. Social Service Note of 10/31/06 outlines that resident speaks only Spanish, but "generally only makes noises." This Social Service Note also outlines that the resident was started on Hospice services on 10/5/06. R1 was in the dining room on 7/19/07 at approximately 9:00 a.m. R1 did not speak when spoken to, but returned a smile.

Specifics of the 5/12/07 incident are documented in the Report of Alleged Resident Abuse, dated 5/15/07. The Resident Abuse Investigation Report outlines that E9, Licensed Practical Nurse, was walking by R1's room and saw R2 with his hand on R1's breast.

On 7/19/07 at 1:50 p.m., E9 said that R2 was "fondling" (R1's) breast area with one hand and "was holding her other hand...It took a couple of minutes for him to let go of (R1's) hand" after E9 told him that this behavior is not appropriate and tried to remove him from R1's room.

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Resident Monitoring sheets for 5/12/07 after 5:00 p.m., 5/13/07, 5/14/07, 5/15/07 and 5/16/07 documenting R2's whereabouts were located and reviewed. E3, Care Plan Coordinator, stated on 7/25/07 at 1:38 p.m., "We place residents on 15-minute checks for 72 hours for any kind of unusual behavior, especially with respect to resident to resident altercations.... We do this to figure out whether there is a new baseline pattern and to protect other residents."

When asking E2, Assistant Director of Nurses, on 7/25/07 at approximately 12:50 p.m. about what assessment was done to determine that R2 no longer needed 15-minute checks, she pointed to Nurses Notes and Social Service Notes. These notes made reference to 15-minute "visuals" in the Nurses Notes of 5/17/07 at 2:00 a.m., and the Social Service Note of 5/21/07 outlines that there were no "further signs of inappropriate behavior." However, there is no evidence of an interdisciplinary decision to stop 15-minute checks because resident was no longer displaying sexually inappropriate behaviors. No behavior assessment was observed and/or provided.

Review of Resident Monitoring Policy showed that a Certified Nurses Assistant will be assigned to monitor the resident identified every 15 minutes or every hour and that this monitoring will be documented on the Monitoring Sheet. There is no reference in this policy that 15-minute checks be stopped after 72 hours.

Social Service Notes, dated 5/16/07, document that R2 was moved from a room on West Wing to a room on East Wing 5/15/07. (Social Service Notes in R1's medical record outline that R1 was

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F9999	Continued From page 12 moved to a room next to the West Wing Nurses Station.) Neuropsychiatry note of 5/15/07 outlines that R2 was involved in "fondling female residents." The note continues that resident remembers the incident and "says he enjoyed it." Note indicates that psychiatrist agrees with moving resident to another room "far from female residents" and increases Seroquel from 25 mg twice a day to Seroquel 50 mg three times a day. The addendum to the note indicates: "(R2) promised to change behavior, but his memory is none too good." Review of Behavioral Observation Monthly Flow Charts for R2 shows that resident was being tracked for "sexually inappropriate behavior, (i.e. -- for example -- inappropriate sexual comments)." Review of the tracking January through July, 2007, shows that there were two such incidents in the entire period, both on July 15, 2007. According to the tracking sheets, there was no sexually inappropriate behavior 5/12/07. E10, Social Service Director, stated on 7/25/07 at 12:40 p.m. that E10 could not explain why the 5/12/07 incident was not documented. E10 was asked what prompted the sexually inappropriate behavior charting in the first place. E10 said "There was an incident in April of 2004 where R2 grabbed a nurse's breasts and periarea...." E10 continued that R2 did not have any other sexually inappropriate behavior until 5/12/07 with R1, as far as she knew. E10 also said that R2 "held hands" about 6 to 8 months ago with R4, an alert female resident. According to E10, there had been no problem with sexually inappropriate behavior in this relationship.	F9999		

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R4 stated on 7/25/07 at 1:00 p.m. that she had not told facility of the problem she had with R2, but that R2 "talked much about sex, for example 'Don't you want to feel this?'" According to R4, R2 then "tried to move my hand to feel him. I got out of his room as fast as I could."

E6, Certified Nurses Assistant (CNA), stated on 7/19/07 at 12:35 p.m., that E6 saw R2 touch R1's leg prior to the 5/12/07 incident when both residents lived on the West Wing. E6 continued that E6 told R2 to stop and R2 did and that R1 "smiled when (R2) touched her."

E5, Licensed Practical Nurse, said on 7/19/07 at 12:15 p.m. that E5 said that after R2 was moved to East Wing, staff "diverted" R2 whenever he was seen going toward West Wing. On 7/19/07 at 12:35 p.m., E6, Certified Nurses Assistant, said that he had seen R2 go to West Wing in his wheelchair after he was moved to East Wing. "He went all the way to the exit door ... and turned around."

E4, CNA, confirmed on 7/19/07 at 12:00 p.m. that R2 could move his wheelchair with his feet and moved "all over the facility." According to E4, resident "seemed to be alert most of the time, found the Physical Therapy Room by himself."

A second incident of inappropriate sexual touching is documented in the 7/16/07 Report of Alleged Resident Abuse. The Report outlines that a dietary staff member witnessed R2 "rubbing" R1's periarea. E8, Dietary staff, was identified as the person who first saw this incident. On 7/19/07 at 3:00 p.m., E8 said that she was walking by R1's room when she noticed R2 in the room,

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facing R1. R2 "had his hands in between her legs," moving them up and down. E8 continued "I immediately reported it to the nurse, (E7)."

On 7/19//07 at 1:08 p.m., E7, Licensed Practical Nurse, said that on "7/15/07 resident did not seem confused. He moved his wheelchair well and purposefully. (E8, Dietary) came to the West Nurses Station to inform me that (R2) was in (R1's) room --- rubbing all over (R1). I immediately went to (R1's) room and found (R2) with his hand on (R1's) pants rubbing repeatedly (R1's) perineal area. I told (R2) to stop. He stopped reluctantly. When I asked (R2) what he was doing, he looked up and said 'I was massaging her.'" R1's room is located next to the West Nurses Station, where E7 was sitting.

R2's Nurses Notes of 7/15/07 at 1:10 p.m. document R2 was sent to behavior unit of a local hospital for "eval (evaluation) et (and) tx (treatment)." Nurses Notes of 7/15/07 at 6:45 p.m. outline that resident returned and was admitted to special unit with "one-on-one watches and 15-min. (minute) visuals sheet implemented." Nurses Notes of 7/16/07, 7/17/07 and 7/18/07 outline that resident continued on 15-minute checks and/or one-on-ones until 7/18/07 when R2 left facility per facility van to be transferred to another nursing home.

(A)